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Comparative Case Study of Liberia and Sierra Leone
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The Local Governance of the 2014 Ebola Epidemic: A Comparative Case Study of Liberia and Sierra Leone

Sabine Iva Franklin

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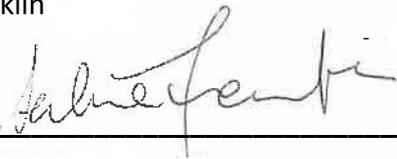
Cher papa, qui aurait pensé que je le ferais? Je t'aime. Cher Marki, nous t'aimerons toujours.

Declaration

I declare that all the material contained in this thesis is my own work.

NAME: Sabine Iva Franklin

SIGNATURE: _____

A handwritten signature in cursive script, appearing to read 'Sabine Iva Franklin', is written over a solid horizontal line.

Abstract

This research investigates community-led interventions in Liberia and Sierra Leone. The objective is to examine the parallels and differences in the response and outcomes of the 2014 Ebola epidemic. Many challenges made aid less effective such as misinformation, rumors, stigma, and logistical difficulties that lowered the demand for aid resources. These market inefficiencies were the demand-side barriers that were prolonging the disease spread.

A qualitative methodology was employed to answer the research question. Sixty-seven semi-structured interviews were conducted from January to July 2017; 33 of these interviews were in Sierra Leone and 34 interviews in Liberia. Informants included health workers, chiefs, chiefs' advisors, a secret society leader, NGO representatives, a government worker, and volunteers during the outbreak. Thematic analysis and the data were supported by NVIVO. The key themes are: 'Government's Response and Community Reaction,' 'Local Institutional Intervention,' and 'Governing the Outbreak.' Informants were chosen through purposeful sampling methods in three provinces in each country.

The findings demonstrate that traditional leaders in Sierra Leone immediately responded through rulemaking and enforcement after the first Ebola case was officially announced. Specifically, rulemaking helped to create behavior changes to increase demand for aid resources, such as mandatory referrals to the health centers. These laws and door-to-door contact tracing were scaled up to a national emergency strategy, relying on traditional leaders to monitor and enforce them. In Liberia, community and traditional leaders organized in many areas to correct some of these demand-side barriers too. In both cases, the response from community-level leaders happened before the international community scaled up aid resources in August 2014, with some donors and humanitarians arriving as late as December 2014.

However, Liberia's local strategies were not scaled up and coordinated nationally, as it was in Sierra Leone. Thus, the interventions implemented were not universal. According to figures by the World Health Organization, Sierra Leone had 25% more Ebola cases than Liberia but had 18% fewer Ebola deaths. This is interpreted as contact tracing and institutional changes having more impact in Sierra Leone to refer Ebola patients into early treatment and reduce deaths.

Key

| | |
|---|---------------|
| Acquired Immune Deficiency Syndrome | AIDS |
| All People's Congress | APC |
| Basic Package of Health Services (Liberia) | BPHS |
| Community Development Reconstruction | CDR |
| U.K. Department for International Development | DFID |
| Ebola Treatment Center/Unit(s) | ETU(s) |
| Ebola Virus Disease | EVD |
| Free Health Care Initiative (Sierra Leone) | FHI |
| Global Health Governance | GHG |
| The Governance and Economic Management Assistance Program | GEMAP |
| Health Human Resources/Human Resources for Health | HRHs |
| Human Immunodeficiency Virus | HIV |
| International Finance Institution(s) | IFI(s) |
| International Health Regulations | IHRs |
| International Monetary Fund | IMF |
| Infection Prevention Control | IPC |
| Limited Access Order(s) | LAO(s) |
| Maternal and Infant Mortality rates | MMI |
| Médecins Sans Frontières | MSF |
| Millennium Development Goals | MDGs |
| Ministry of Health and Social Welfare (Liberia) | MHSW |
| Ministry of Health and Sanitation (Sierra Leone) | MOHS |
| National Ebola Response Centre (Sierra Leone) | NERC |
| National Transition Government of Liberia | NTGL |
| Nongovernmental Organization(s) | NGO(s) |
| Open Access Order(s) | OAo(s) |
| Organization for Economic Co-operation and Development | OECD |
| Personal Protective Equipment | PPE |
| Poverty Reduction Strategy | PRS |
| Public Health Emergency of International Concern | PHEIC |
| Revolutionary United Front | RUF |
| Standard Operating Procedure(s) | SOP(s) |
| Structural Adjustment Program(s) | SAP(s) |
| Sub-Saharan Africa | SSA |
| Sierra Leone People's Party | SLPP |
| Traditional Local Institutions | TLIs |
| United Nations | UN |
| United Nations Security Council | UNSC |
| Universal Health Coverage | UHC |
| Viral Hemorrhagic Fever | VHF |
| World Health Organization | WHO |

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INTRODUCTION

THE SPECIFIC CASE OF THE 2014 Ebola epidemic in Liberia and Sierra Leone is investigated for parallels and differences in local governance and response. In the context of these sub-Saharan African (SSA) countries, Traditional Local Institutions (TLIs) are the norms and customs that are governed by traditional leaders termed paramount chiefs, chiefs, clan leaders, councils, monarchs, youth leaders, and secret society leaders. The paramount chiefdom is a legally recognized order of government and public administration. The chiefs are supposed to be elected and serve as local authorities; however, the relationship, governance, and legitimacy vary in different SSA countries. State institutions are, instead, rules and customs governed by the state and its government.

The chapter is structured as follows; section I discusses the motivations for carrying out this research. Then section II is on the scope of the thesis regarding traditional leaders and their role governing the 2014 Ebola epidemic in West Africa. Under this section, key terms used throughout the thesis are explained, in addition to the investigation, research question, and the narrative. The narrative helps to summarize the thesis and key elements of this narrative that will appear in the respective chapters. Section III discusses key concepts that came up during the research of this phenomenon. It begins with a timeline of key events during the 2014 Ebola epidemic, informed by the literature and interviews from informants. Then it presents the theoretical framework it uses to explain the phenomenon. The final section is the chapterization of the entire thesis.

I. Statement of Purpose

My intention to cover this topic is motivated by my interest in understanding why the West African countries' health infrastructures were weak after several years of post-conflict development. In addition, how the epidemic transformed the discussion around aid and health interventions. According to Kirton (2014), disease knows no boundaries and an underdeveloped healthcare system in one country can escalate to a regional or global crisis; a lesson learned from various world pandemics.¹

¹ There is a difference in terminology between a pandemic, epidemic, outbreak, and endemic. An outbreak is an occurrence of a disease, usually in larger numbers than expected, but an outbreak can happen in a small area, such as one neighborhood. A pandemic is a disease outbreak that covers very large geographical areas such as an entire continent, or

Since the turn of the millennium, there has been a growing interest in health as a foreign policy and as a development policy to promote economic growth. According to Kassalow (2001), since the height of the HIV/AIDS pandemic, health problems in low-income countries are no longer seen as soft factors and need to be prioritized in terms of global and regional security, development, and trade interests. The vast literature questioning aid and its effectiveness, from radical approaches like Kothari (2005), to macroeconomic studies such as Easterly, Levine, and Roodman (2004), cast doubt on the effectiveness of foreign aid.

I researched the concepts of good governance policies that purport to make institutions stronger for development, and for improving the governance of healthcare systems. The findings from the field showed that state institutions were performing poorly but surprisingly, TLIs not only provided knowledge, accountability, and supported community engagement, but also influenced policy. Therefore, these findings can redefine the current debate on good governance (Gray, 2016; World Bank, 2002; World Bank, 2017). It also fits in the discussion of institutional change and institutional quality, in terms of rural-based institutions (Baldwin, 2015; Baldwin and Mvukiyehe, 2015; Bulte, Richards, and Voors, 2018; Casey, Glennerster, and Miguel, 2012; Pande and Udry, 2005) and how traditional leaders can impact development and governance (Baker, 2007; Baldwin, 2015; Casey, Glennerster, and Miguel, 2012; Dia, 1996; Sesay, 2019; Tokpa and Yengbeh Jr., 2012; UNDEF, 2014; Unsworth, 2010; Van den Boogaard, Prichard, and Jibao 2019). And at the empirical level, the role of traditional and community leaders who organized during the West African Ebola outbreak (McMahon et al., 2017; Parker and Allen, 2018; Parker et al., 2019; Perry and Sayndee, 2017; Richards, 2016; Van der Windt and Voors, 2020).

II. Scope

This section explains the scope of the thesis. First, it gives a brief analysis of what TLIs are and why they are important in today's world. Part A briefly conceptualizes key terms that will be used throughout this document. There are debates regarding the terms

in the case of HIV/AIDS, worldwide. For the case study of the 2014 Ebola disease eruption, the literature uses "outbreak" and "epidemic" interchangeably and so does the thesis. See Morens, Folkers, and Fauci (2009), Pandem-Sim, (2017), and World Health Organization (2010) for more reading on these terminologies.

used, however, these debates are out of scope for the thesis. However, the controversy of these terms should be acknowledged and explained why the terms are chosen. Part B briefly describes the investigation of key concepts that bind the theoretical framework. Part C introduces the research question and part D gives the narrative.

The chiefdom institution in SSA extends well before the European colonial period and has shown resiliency, despite changes in power structures during and after colonialism (Davidson, 1998; Tokpa and Yengbeh Jr., 2012). In Sierra Leone, British colonizers reshaped hierarchical structures in the society, consolidating the powers of the chiefs (Acemoglu, Reed, and Robinson, 2014). As for Liberia, it gained independence in 1847 as Africa's oldest republic and second free Black republic, after Haiti (BBC News, 2019; Office of the Historian, 2016). However, tribal leaders were not incorporated into the administrative affairs of the central government in the capital of Monrovia. Indigenous ethnic groups were left with magistrates until the mid-twentieth century (Tokpa and Yengbeh Jr., 2012).

Today, TLIs are still effective and the leaders are part of the elite political class in many parts of SSA. Liberia and Sierra Leone are decentralizing executive and legislative affairs since the conflict period, but chiefdoms and clans are formally recognized as local jurisdictions. The authority of traditional leaders includes the ability to pass laws and impose penalties, without parliamentary or senate approval (Chieftaincy Act, 2009; The Local Government of 2018, 2018). It is important to clarify that these institutional structures vary, with some having a top-down legal and administrative structure while others may be acephalous (D'Azevedo, 1989; Mulbah, 2018). Thus, during the 2014 Ebola epidemic, several chiefdoms implemented similar bylaws in Sierra Leone. These were considered useful and implemented into a nationwide strategy, promoted by the central government in Freetown. In this sense, the phenomenon under study is an interesting example of rulemaking, high institutional quality, and good governance.

The thesis analyzes the phenomenon of rulemaking and TLIs during the epidemic. It uses a market approach to understand supply and demand factors in governing a disease outbreak; and how institutions can govern specific challenges related to supply or demand barriers.

A Terminology

This section discusses some terms that are used throughout the thesis and why these terms were chosen for clarity and consistency.

i. Traditional Local Institutions

The literature has various terminologies to refer to local authorities and institutions that may be confusing for the reader. Therefore, the thesis uses traditional local institutions (TLIs) for consistency and clarity.

Unsworth (2010)'s research in South Asia identifies these institutions as, Informal Local Governance Institutions with traditional leaders or chiefs, whose existence can be traced back to the indirect rule of European colonial administrations. However, many countries have chiefs that existed long before the colonial period (Davidson, 1998).

Informal ('traditional') local governance institutions [ILGIs] are persistent, influential and very diverse. The extent to which they exercise effective and acceptable public authority reflects both their origins, and the contemporary institutional context in which they operate. Efforts to improve local governance need to take account of this diversity. Some informal local governance institutions can work synergistically with formal institutions; in other cases, they may undermine or weaken them. Looking at the origins of ILGIs might provide a useful guide for better targeting of development programmes. (Unsworth, 2010, p. 71)

The term, 'informal' institutions, has been broadly used in the literature to mean 'norms and behaviors' and specifically in development and political studies to refer to corruption or patrimonialism (Bratton, 2007; Dreher, Kotsogiannis, and McCorrison, 2009; Khan, 2010). However, this terminology used in Unsworth (2010) and Pande and Udry (2005) are local institutions where the norms and customs are governed by traditional leaders, termed paramount chiefs, chiefs, or village councils. Khan and Mehmood (2016)'s analysis on the role of elders during the conflict period in Swat, Pakistan, also refer to them as informal institutions and reveal their ability to play a positive role in resolving conflict. In addition to their ability to raise militant groups, as radicalized Imams encouraged local youths to join the Taliban.² Likewise, Bratton (2007) include traditional leaders as informal institutions since they govern through patron-client networks, however, clientelism operates through state institutions too.

Therefore, non-state institutions are more than the corrupt or clientelist practices that scholars focus and sometimes term as, 'weakening institutions or poor governance.' 'Informality' is the practices or norms beyond the state's reach, but the status and authority of these leaders are officially recognized in the constitutions of many African nations. So,

² The definition varies, as Khan and Mehmood (2016) include religious leaders, like Imams and mosques, in the definition of informal governance institutions, but they were not included in Unsworth (2010)'s research.

historically they may have been seen as informal and having poor governance (Acemoglu, Reed, and Robinson, 2014; Hanlon, 2005; Jackson, 2005; Richards, 2005), but are very much part of the political and legal structure of the domestic societies, (Fanthorpe, 2001; Fanthorpe, 2006) and have took part in various local development projects too (Baldwin, 2015; Casey, Glennerster, and Miguel, 2012; Unsworth, 2010).

Others use the term, ‘traditional’ to refer to these institutions (Iyanya, 2018; Ubink, 2008). Iyanya (2018) says that, although he uses the term ‘traditional’ in his case study of the Igede ethnic group in central Nigeria, this term implies a locally created custom that had evolved. However, that may not be the case in some places because British colonial rule changed the chieftaincy administration in many countries (e.g. Sierra Leone) by inserting ruling families that reflected the imperial monarchy institution of Europe; whereas precolonial chieftaincy was based on a gerontocracy, such as a council of elders (Iyanya, 2018). The term ‘traditional’ also implies a static institution. However, chapter two further discusses how traditional leaders have been incorporated into modern development and governance efforts.

A third option is the term ‘indigenous’ (Dia, 1996; Watson, 2003). This is defined in the context of power, meaning it is applied to those, “who have been marginalized in the past from dominant forms of governance and knowledge,” (Watson, 2003, p. 290). However, this would only apply in some contexts, such as the case of Liberia where indigenous ethnic groups were marginalized by the Americos.³ Thus, this would not be suitable as a general term for this thesis, since traditional leaders are part of the political elite. The term ‘traditional’ is preferred, although it does not mean these institutions are static or archaic.

The term, TLIs, also broadly encompasses secret society leaders,⁴ which have not always been included in prior works examining the governance of traditional authorities in

³ The history of Liberia will be discussed in chapter one, section 1.3. However, the Americos are descendants of repatriated slaves and historically, this minority dominated the political and economic landscape of the country, largely marginalizing other ethnic groups.

⁴ Secret Societies are organizations that govern religious and cultural customs and there are multiple societies (Little, 1947; Little 1949). Marriott (1899) says most of these societies in West Africa are “tribal” except for the *Poro* which can be found in many countries in this region. However, Day (2012) and Moran (1989; 2012) say the secret societies also have political and social roles in contemporary West Africa. The *Sande or Bundu* society (also spelled *Bondo*) gives status to older women and women from dominant lineages, even over junior males (Day, 2012; Moran, 2012). However, the patriarchal system is still reflected in the overall society (Moran, 2012). *Sande* is a term used by the Mende ethnic group in West Africa for the female secret society (Day, 2012). Some of these works only examine the societies, but not vis à vis the chieftaincy and governance.

Africa, except for a few studies such as Jackson (2006; 2011), Moran (1989; 2012), and Richards (2016). Given that secret societies also have a role to play in local politics and governance, not least because in some areas the chief is also the head of the society, thus, it makes sense to include them. For example, during the 2014 Ebola epidemic, secret society leaders were consulted by the chiefs in implementing and enforcing emergency management regulations (Richards, 2016).

ii. Rulemaking

‘Rulemaking’ is the term that is used for this research as it distinguishes it from other strategies of community engagement or collective action. In institutional theory, institutions are the norms and laws of society (North, 1990). So, the leaders of the institution engage in rulemaking for legal and social purposes. The reason for using this is because rulemaking from the paramount chiefs was an internally devised strategy, created before humanitarian aid resources began to scale up in August 2014 to address the disease outbreak. In the second chapter, in section 2.6, the literature debates various community engagement strategies for a disease outbreak response. However, these tend to be externally led by external partners. In addition to why rulemaking is preferred, it is because the paramount chiefs are the political elite and ‘collective action’ is sometimes used to describe how a marginalized group organizes for change (Scott, 1992). These actors are not marginalized in their communities and the findings show that traditional and community leaders participated in other engagement efforts, other than making and enforcing laws.

iii. Good Governance

‘Good Governance’ is a term broadly used in the development studies literature to refer to the World Bank’s policies and macroeconomic reforms for recipient countries of aid (Nyei, 2014; Tirman, 2005; World Bank, 2002). “Good governance includes the creation, protection, and enforcement of property rights, without which the scope for market transactions is limited...” (World Bank, 2002, p. 99). This concept was developed from Douglass North’s theory of institutions and institutional quality (Gray, 2016; World Bank, 2002). Throughout the thesis, unless it is specified otherwise, ‘good governance’ and

‘institutional quality’ are used interchangeably, as they are referring to the scope of liberal economic reforms with the intended output of economic growth.

iv. Community Engagement

The thesis uses the term ‘Community Engagement’ to capture all community-level intervention strategies depicted in the literature. However, the declaration of the 1978 *Almá Atá* Conference on primary healthcare defines community engagement much more holistically than as a bottom-up perspective (World Health Organization, 1978a). Therefore, different terminology, such as community/health sensitization, social mobilization, community outreach, community participation, etc...denotes different levels and degrees of community engagement, including some strategies that are top-down. Also, the methods of development and engagement can exclude the perspectives of marginalized people.⁵

There is an initiative led by a group of nongovernmental organizations (NGOs), including the Red Cross and Red Crescent Movement that created universal minimum standards that should be practiced in all humanitarian responses: the Sphere Standards (Sphere Association, 2018). Under guidelines for disease outbreaks, there are Infection Prevention Control (IPC) practices and it says that it may not be possible to implement all these practices, but instead, to let community engagement guide how to implement safer IPC during a disease outbreak (Sphere Association, 2018). Community engagement is defined as working with the patients and community to improve access and acceptability of care, and to implement feedback mechanisms (Sphere Association, 2018). However, the handbook does not specifically define a ‘community’ or how humanitarian workers can ensure they are engaging with the right stakeholders to achieve this. So, implementing community engagement is not universal as different organizations may use different strategies and channels to reach the community with varying degrees of success. Additionally, these strategies do not always include local knowledge in formulating a response.

⁵ Assessments for strategies and mobilization may not always consider the voices of local people. These paradigms are created by development or humanitarian professionals. So, some terms may also reflect levels of power between professionals and the poor. See Chambers (1997) on techniques of participatory rural appraisal. Also, to understand concepts of public participation, constructs of power, and how this broadly impacts policy, see Arnstein (1969).

Consequently, the literature review in chapter two, section 2.6, shows various and sometimes conflicting ideas of ‘community engagement.’ However, it is not the scope of the thesis to define these terminologies or to argue which strategy worked best. It is only acknowledging that donors and humanitarian organizations have their strategies, and these are not governed or enforced by any single international agency. Although the Sphere standards are used broadly and well known, including within the World Health Organization (WHO) to develop intervention strategies during a humanitarian response (World Health Organization, 2013), practices still vary. This may be conflicting at times if one source shares the same label with another source, but each implements their respective strategies differently.

v. Public Health Emergency

Under the WHO’s 2005 International Health Regulations (IHR), the WHO has the authority to coordinate an international response to an extraordinary event that poses a threat to global health security (World Health Organization, 2018c). These regulations have only been enacted a handful of times since coming into effect in 2007. However, the WHO and other partners do respond in a coordinated fashion to disease outbreaks without declaring it a Public Health Emergency of International Concern (PHEIC). Thus, mentioning the PHEIC helps us to understand that the 2014 Ebola epidemic is a public health emergency. Specifically, this is to differentiate it from other public health crises, such as the chronic crisis with the HIV/AIDS pandemic or growing concerns to target non-communicable diseases. As Kamradt-Scott (2011, p.1) defines it,

A sense of immediacy can be appropriately inferred from this qualification—immediacy further corroborated by the inclusion of the term “emergency” within PHEIC—supporting the commonly held view that the IHRs are designed to deal with acute (as opposed to chronic) public health conditions that are readily transmissible and disruptive to international trade.

This quote conceptualizes how ‘public health emergency,’ is used in this thesis: as an outbreak of an infectious disease that poses a threat to the security and stability of the state and requires an international response. This is slightly different from the WHO’s definition, which includes bioterrorism (World Health Organization, 2018b). However, the literature review is not limited to events where a PHEIC was declared. Before the 2005 IHRs came into effect, if a nation had a public health emergency, it invited the WHO, technical expertise, and coordinated aid resources (Kamradt-Scott, 2015).

B. The Investigation

Whilst investigating the research question, I used broad concepts of community engagement, aid, and health governance. There is a plethora of literature and research available across the disciplines of economics, public health, development studies, political economy, and international relations.

These tend to focus on long-term effects on the healthcare system, such as social equity, health status, health promotion (Abbott, Sapsford, and Binagwaho, 2017; Ayo, 2012; EQUINET, 2007; Evans, Elovainio, and Humphreys, 2010). In addition, some literature gives a macro perspective of how donors, such as the World Bank and International Monetary Fund (IMF) finance the development of healthcare systems in low-income countries (Johnston, Deane, and Rizzo, 2015; Navarro, 2007; Rosser and Bremner, 2015). However, since this is an examination of a disease outbreak, the scope was narrowed to the literature on disaster-relief and humanitarian aid that is supplied during such occasions. The political economy and international relations literature tend to focus on the areas of conflict and security or natural disaster response (Duffield, 2013; Jaspars, 2018; Roderick, 2006; Tirman, 2005). However, it seems that when it comes to public health crises, the amount and scope of the academic literature is vastly on the chronic HIV/AIDS pandemic and the recent 2014 Ebola epidemic. The reason for this examination of public health crises, and not all complex humanitarian emergencies, is because stigma and fear often lead to demand-side barriers, where some people may refuse health care.

Additionally, community engagement and response strategies are different in a disease outbreak than in other disasters (Arola, 2008). During the West African Ebola epidemic, and to a lesser extent with HIV/AIDS, there was stigma (NPR, 2014; Pisani, 2011). In the 2014 Ebola Virus Disease (EVD) outbreak, health workers were stigmatized for spreading the disease and many people were afraid to receive care (Dixon, 2014; Fofana, 2014b; Pellecchia et al., 2015). One does not encounter such stigma or response from survivors or families affected by an earthquake or flooding. So, the training, research, or lessons learned from the generic disaster literature would not have the same dimensions in terms of getting communities to cooperate or participate.

C. Research Question

The thesis seeks to understand the parallels and differences in how the Ebola outbreak was managed in the case study countries. The aims and objectives are steps to examine how governance is perceived in the literature and the significance of community-led engagement during a disease outbreak. By examining these different components of aid, governance, and community engagement in health, I seek to contribute to this debate on how local actors managed the outbreak in their respective countries and how their governance contributed to the overall response.

In the context of fragile states, aid is channeled through NGOs or the private sector to deliver services or public goods. This is because they are seen as having good governance when states are weak, as explained in Dietrich (2013). However, there is a gap in the current discourse on how TLIs have good governance for social outcomes, and how the response to the Ebola epidemic overall was shaped by institutions responding at different levels (national and local) that either helped or hindered governance of the crisis. This was divided into two aims and four objectives to answer the overall research question.

The specific aims and objectives of the thesis are listed below:

- Investigate the role of TLIs and community-level leaders during the 2014 Ebola epidemic in Liberia and Sierra Leone
 - A) Examine how the responses of state and community-level institutions differed.
 - B) Identify challenges that hampered the management of Ebola identification and prevention at the local level.
- Examine the links between community engagement and aid performance in public health emergencies.
 - A) Examine what the narratives of health workers and community stakeholders tell us about the overall response and how the disease outbreak was managed.
 - B) Examine what the literature says about the community's impact on aid resources.

D. Narrative

The scope of the literature reviewed fits with the concepts mentioned above of institutions, public health emergencies, and good governance. The first dimension examines the overarching framework on institutions, which includes the debate on good governance and institutional quality and why people cooperate. The second dimension

examines strategies of aid resources and community engagement. This dimension examines supply and demand factors in the specific context of a public health emergency. Finally, the third dimension examines how demand-side barriers impacted the 2014 EVD outbreak in Sierra Leone and Liberia, and how local institutions responded.

The research question was informed by gaps in the literature, which do not fully explain the role of TLIs in emergency management, and when community engagement strategies are top-down. Especially when large numbers of external partners, donors, and humanitarian organizations are involved in the response. In the context of Sierra Leone's emergency response, TLIs helped to overcome demand-side barriers, such as lack of trust, misinformation, and lack of coordinated leadership. In this case, high institutional quality (good governance), defined as correcting information failures and reducing social costs during the crisis, made the response more effective. While Liberia faced similar governance challenges, including the lack of trained and supported health workers; we do not find any evidence of coordinated leadership that was scaled up nationally. Instead, local communities organized independently to reduce or prevent cases of EVD.

The authority and involvement of paramount chiefs and other community leaders helped to bring cooperation, restore trust, and encourage sick persons to visit the health facilities for testing and treatment. The organizations of the paramount chiefs and the secret societies are respected and have more influence in rural areas, where often the central government lacks presence and trust. The WHO says a lesson learned from the response in Liberia was, "Intensification of technical interventions, like increased laboratory capacity, more treatment beds, and a larger number of contact tracing and burial teams, will not bend the curve in the absence of community engagement and ownership," (World Health Organization, 2015c). This is referring to the supply-side of the intervention, which is how international donors and NGOs tend to engage. This means bringing resources, such as drugs, mobile treatment centers, or ambulances, and technical assistance, such as epidemiologists or trainers. However, without community engagement, intervening with only these resources is unlikely to change the pace of the disease spread.

Soon after the WHO declared the 2014 EVD outbreak a PHEIC in August 2014, and officially intervened; it assessed the situation in Sierra Leone. It found that the epicenter in the eastern region had begun to resolve itself, and thus, would be mainly concentrating

their efforts in the western and northern regions (World Health Organization, 2014a). The epicenter in Liberia, Lofa County, had resolved its EVD cases in November 2014 (World Health Organization, 2015C).

The findings indicate that, during the 2014 Ebola epidemic, TLIs in Sierra Leone passed bylaws⁶ to curb the disease spread. Local communities see these institutions as trustworthy, legitimate, information brokers, and accountable to constituents, however not all traditional leaders govern in this manner (Acemoglu, Reed, and Robinson, 2014; Beekman, Bulte, and Nillesen, 2013; Beekman, Bulte, and Nillesen, 2014; Hanlon, 2005; Jackson, 2005; Jackson, 2006; Mamdani, 1996; Peters and Richards, 1998; Richards, 2005). Those traditional leaders who are not accountable may be overthrown or lose their constituency (Baldwin, 2015; Fanthorpe, 2006; Hagan et al., 2015; Logan, 2013). These qualities of TLIs are what led to a turning point in some areas, before the WHO officially intervened. These qualities also make them effective mediators of aid performance in Sierra Leone. In Liberia, community engagement occurred but it was sporadic and sometimes unsupported by donor resources and state institutions.

III. Researching the Ebola Epidemic

The 2014 Ebola epidemic was a humanitarian crisis that reignited a debate regarding the limitations of development, aid intervention, global health governance, and the domestic states' infrastructure and response (Abramowitz, 2014; Benton and Dionne, 2015; Boseley, 2014; Cenciarelli et al., 2015; Chandler et al., 2015; Drain, 2015; DuBois et al., 2015; Farmer and Mukherjee, 2014; Gostin and Friedman, 2015; Grover et al., 2016; Gulland, 2014; Gupta, 2015; Gupta, 2017; Kamradt-Scott, 2016; Nunes, 2016; Obilade, 2015; Pailey, 2017; Quinn, 2016; Robinson and Pfeiffer, 2015; Stubbs et al., 2017a; Transparency International, 2015). Through literary sources and primary data (key informants), a brief timeline was constructed to depict how events unfolded in the beginning stages of the EVD outbreak. This thesis divides the timeline into two periods: phase one from December 2013 to September 2014 and phase two is from October 2014 until the disease outbreak was declared over in June 2016. This is different from how the

⁶ The word bylaw is spelled differently in different countries or different sources, sometimes byelaw or by-law is used. The thesis uses the spelling 'bylaw' consistently unless it is directly quoting a source.

WHO classifies the phases during this outbreak.⁷ The reason for this is because it captures the timeline from the informants' view of notable events, especially during the first several months before the international community mobilized aid resources. The thesis holds that creating this timeline decolonizes the historical narrative of the outbreak by centering a timeframe from the perspective of local actors (the ones who 'do not write history'). This is inspired by Chakrabarty (2000)'s work on global history.

Chapter one, section 1.6, introduces the challenges faced during the intervention, however, this focuses on the supply-side of the market. Chapter two, section 2.7, discusses community engagement strategies and local responses in West Africa, hence, it focuses on the demand-side barriers. It is divided this way, as chapter one provides historical context and the literary debate in chapter two is where the thesis makes it theoretical and evidence-based contributions to knowledge.

A. Timeline

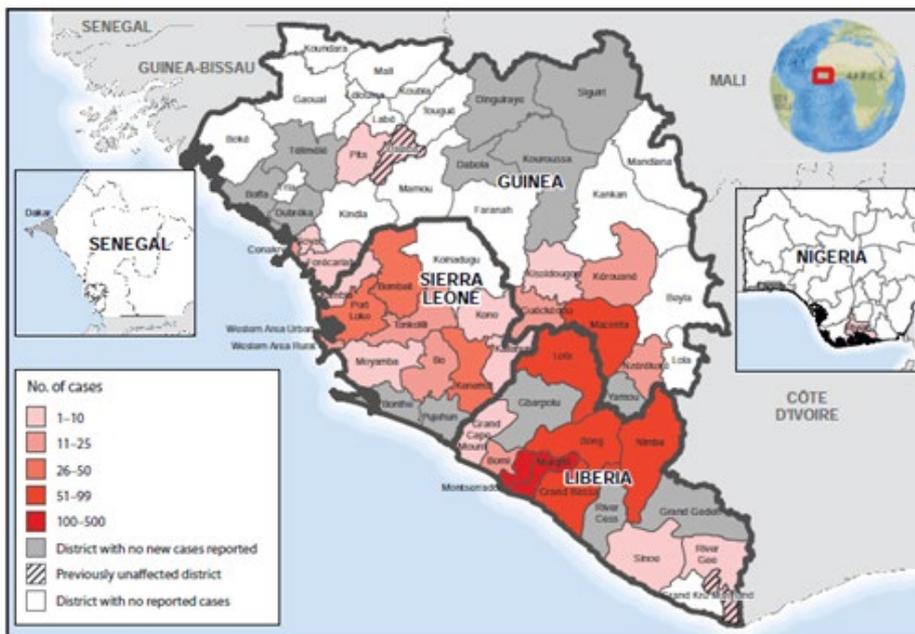


Figure 1 Former epicenter of Kailahun and Kenema districts and Lofa County had decreased EVD cases. September 28 to October 18, 2014 (Centers for Disease Control and Prevention, 2014)

⁷ The WHO divided the phases in the EVD outbreak according to the epidemiology of the disease spread (World Health Organization, 2015f). They classify phase one as from August to December 2014, after declaring a PHEIC. This leaves out all epidemiology information for the first nine months of the outbreak (December 2013 to August 2014), including local efforts to contain the disease spread. This also means that epidemiology data before August 2014 are less reliable and accurate.

The first Ebola infection was confirmed in a young boy in the Guéckédou prefecture in the forested region of southern Guinea. It is believed that he encountered a fruit bat, a suspected reservoir of EVD,⁸ in December 2013 and subsequently passed away (Marí Saéz et al., 2015). There were rumors of mysterious deaths in this remote part of the country (Toukara, 2014), however, the Guinean ministry of health announced that the illness, which had killed thirty-four people, was EVD on March 22nd (Africaguinee.com, 2014). Meanwhile, Conakry, the capital of Guinea, had experienced three consecutive waves of EVD from February to August 2014 (Faye et al., 2015). It was the first major urban center affected in this outbreak. On March 30, 2014, the Government of Liberia confirmed its first EVD case in the Northern rural county of Lofa, which borders Guinea near where the young boy died. On April 2nd, a case is confirmed in Monrovia on the Western coast (Davies and Rushton, 2016). Around that time in April, there are reports that officials were in Sierra Leone investigating some mysterious deaths, however, the first case of EVD is confirmed on May 25th (DePinto, 2016).

In Sierra Leone, the index case (first patient) was a nurse working in Koindu, which is not far from the Guinean and Liberian borders. A paramount chief, who was also a trained nurse, heard about the case at a clinic in his chiefdom, and immediately traveled to the rural village of Daru (Richards, 2016). An exact date is not given, but Richards (2016) and primary data suggest that all the paramount chiefs in the rural eastern Kailahun District, passed a set of bylaws in June 2014. The nurse passed away from EVD, soon after arriving in Sierra Leone. In June 2014, new cases appear in other parts of the country, including in the west, where the capital Freetown is located.

In Liberia, Lofa County had two waves of EVD, the first in March 2014, which declined after a few weeks, but it reignited again in late May 2014 (Fast et al., 2015). Fast et al. (2015) say that EVD was imported in, but it is not clear if they meant from another country or perhaps, from somewhere else within Liberia. In August 2014, President Ellen Johnson-Sirleaf declares a state of emergency (BBC News, 2014b). According to informants

⁸In infectious disease ecology and epidemiology, a natural or disease reservoir is any plant, animal, or human that can host a disease without having symptoms but can spread this disease to others. It is unknown which animal or plant is a reservoir for EVD; scientists have looked since the 1970s and narrowed the search to a few species of fruit bats. See Groseth, Feldmann, and Strong (2007), Marí Saéz et al. (2015), Pourrut et al. (2005), Preston (2012), Taylor, Leach, and Bruenn (2010).

from the field, some local communities began organizing as a response to the Government's announcement and perceptions on how it was responding.

In the rural eastern Kenema District of Sierra Leone, the paramount chiefs are persuaded to adopt bylaws, according to the informants. It is said this happened in July 2014. However, from that time until August, President Ernest Bai Koroma hears about the bylaws in the two rural districts and the subsequently decreasing EVD cases. He asks all the paramount chiefs in the country to implement bylaws and integrates these into a state of emergency declaration on July 30, 2014 (Barbash, 2014; Government of Sierra Leone, 2014).

The WHO declares the Ebola epidemic in West Africa to be a PHEIC on August 8, 2014 (World Health Organization, 2014c). This authorizes it to mobilize aid resources without an official invitation from the domestic governments. However, by September 2014, EVD case incidences stabilize in the Kailahun and Kenema districts. Thus, according to the WHO, these districts are no longer epicenters of the disease outbreak (World Health Organization, 2014a). Different neighborhoods in Liberia conduct community engagement efforts, such as setting up checkpoints and door-to-door health education, according to the informants. According to Kouadio et al. (2015), EVD cases also begin to decline in Lofa County, a former epicenter, and this county had the highest rate of EVD survivors.

i. The Delay in Aid

There were health-related aid resources in West Africa before the Ebola epidemic; NGOs accounted for most of the health services delivered in both countries. However, according to informants, some resources were leaving due to pre-arranged agreements or some continued to provide services during the outbreak. In addition, informants say that the Chinese government had sent aid resources during phase one, specifically, ambulances. Uganda had also sent experienced volunteers to train health workers on safely caring for EVD patients. However, the scale up of mainly Western derived aid resources, such as the WHO, United States, and the United Kingdom did not occur earlier than September 2014.

In an interview, the former WHO Director-General explained that the organization's main role is to provide technical assistance and it is not a first responder; hence why it did not respond sooner than August 2014 (Fink, 2014). However, Kamradt-Scott (2016)'s

research found that there were long-standing structural issues, such as 2005 IHRs; this gave the WHO authority to coordinate an international response, however, it is under strict guidelines that require a majority vote from the member states to determine if an event meets the definition of a public health emergency. Another structural issue that hampered the agency's response was a 51% budget cut voted by the members in 2013. This resulted in large layoffs in the emergency response team, from 90 to 36 persons (Kamradt-Scott, 2016). However, that same year, the World Health Assembly voted for the WHO to have greater responsibilities in humanitarian responses, including mental health services during a crisis (World Health Organization, 2013). The WHO responded that a PHEIC is sometimes confused with an operational response, which it is not. The agency claims it mounted an operational response when it was first notified of EVD in West Africa (Ippolito, Di Caro, and Capobianchi, 2015).

Thus, there was a global response to mobilize aid and send resources to West Africa. However, by the Spring of 2015, some resources began to scale down or withdraw because of declining case rates, such as troops sent by the United States Agency for International Development (Bullard, 2018; Giahyue, 2015).

B. Theoretical Framework

The theoretical framework has three dimensions in its scope, as it addresses a gap in knowledge at each dimension. This is discussed in the literature review in chapter two. Since TLIs, mainly operate in the rural and remote context, they are not often examined for institutional quality or impact on external factors such as aid, the economy, or emergencies. The thesis extends the concept of institutional quality to examine TLIs for social outcomes and not just economic growth.

The first dimension is represented in figure 2 below, the top image represents the original theoretical framework with the concepts of rulemaking, protection of property rights, monitoring and enforcement, social capital, and low transaction costs. These are considered concepts of high institutional quality for economic growth (Dreher, Kotsogiannis, and McCorriston, 2009; North, 1990; Rodrik, 2004; World Bank, 2002). The bottom image is the framework extended with two new concepts the thesis is exploring in the orange hexagons, the ability to correct information failures and social costs. These two

market failures have been used before in social economics and health interventions (Becker and Becker, 1997; Jha and Chaloupka, 2000), but not in an institutional analysis.

Figure 2. Theoretical framework



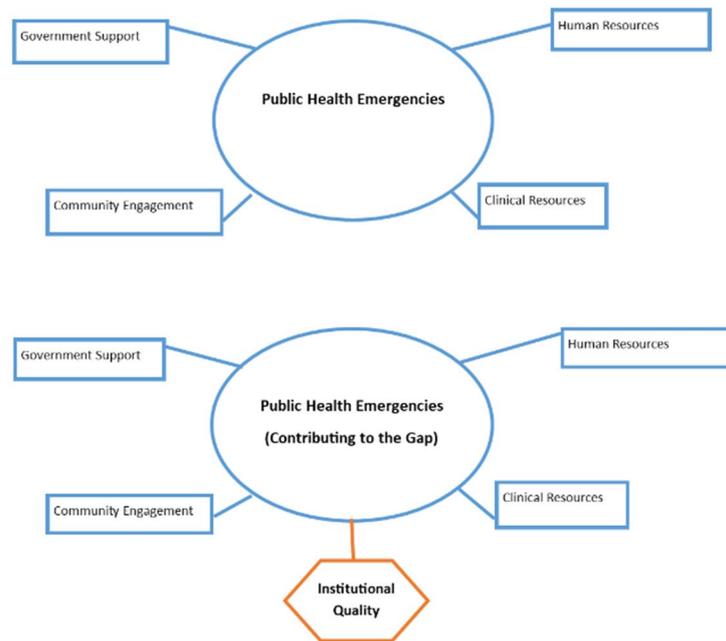
The second dimension examines community engagement strategies during a public health emergency. A public health emergency is defined as an acute infectious disease outbreak as explained above in section II, part A. Each NGO or donor has its specific strategy to supply aid and engage with the local communities. For example, the global health cluster (WHO, United Nations Children’s Fund, and Food and Agriculture Organization) has a strategy that it endorses to provide health education and community sensitization during a disease outbreak (World Health Organization, 2012a). Additionally, there are the Sphere standards as mentioned above. However, institutional quality and TLIs are not thoroughly discussed at this level. The literature suggests that community stakeholders were passive recipients of health promotion or cooperated to fulfill the agendas of external partners.

In figure 3 below, the top image depicts key concepts from the disease outbreak literature discussed in chapter two, section 2.6 (Allaranga et al., 2010; Centers for Disease Control and Prevention, 2007; Cohen, 2018; Enserink, 2005; Georges et al., 1999; Ilunga

Kalenga et al., 2019; Lamunu et al., 2004; Médecins Sans Frontières, 2018a; Médecins Sans Frontières, 2018b; Médecins Sans Frontières, 2019; Moran, 2018; Msyamboza et al., 2014; Muñoz, 2017; Nkengasong and Onyebujoh, 2018; Okware et al., 2002; Onyango et al., 2007; Roddy et al., 2007; U.K. Department for International Development, 2011; World Health Organization, 2007; World Health Organization, 2009) These concepts in the blue boxes include bringing clinical resources, such as medicine, gloves and masks, ambulances. The human resources concept is depicted by training health workers on how to manage and treat suspected patients and training volunteers to do health education in the communities. Government support is usually the ministry or department of health that is collaborating with the agency for logistical support. A community engagement strategy is sometimes mentioned in the literature or cultural barriers are discussed. At this level, the literature portrays the lead agency as correcting supply and demand-side barriers after implementing its strategy of supplying technical resources and expertise, this includes the expertise of overcoming community perceptions.

The bottom image shows an orange hexagon of institutional quality, which is a gap in the literature that the thesis intends to address. Using the extended framework, where institutional quality includes the concepts of correcting information failures and reducing social costs.

Figure 3. Second Dimension in the literature review.



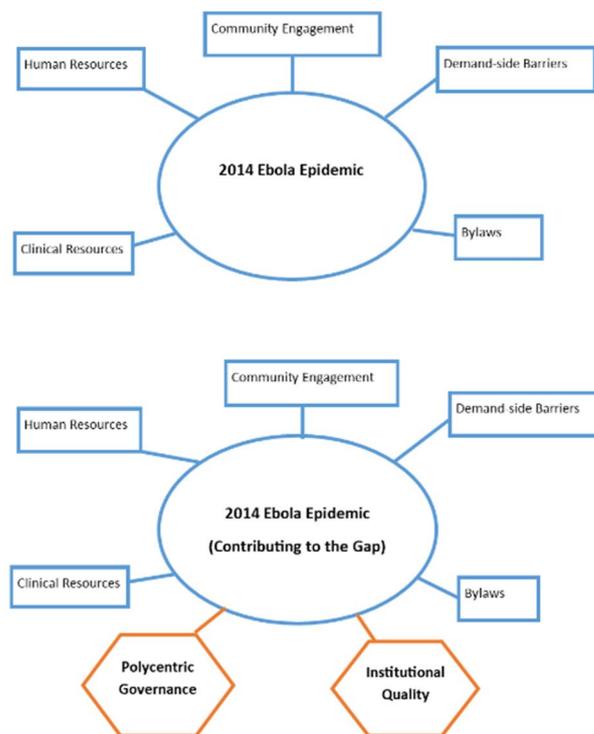
The third dimension is the 2014 Ebola epidemic, where the literature on community engagement strategies and aid expand to discuss the challenges of the traditional strategies and the importance of engaging with local communities. The bylaws passed by paramount chiefs in Sierra Leone are discussed, but not in relation to institutional quality, and how multiple levels of institutions collaborated or hindered governance efforts of this outbreak. Community engagement in Liberia is also discussed, but not analyzed from this perspective.

In the top image, the boxes of ‘human resources’ and ‘clinical resources’ are the same concepts as before. ‘Community engagement’ is also the same as defined above, however, the literature varies on what this means, including Perry and Sayndee (2017)’s book entitled ‘Social mobilization in Liberia’ but it discusses how communities self-organized, rather than agency-led strategies. We see another box called ‘demand-side barriers.’ This concept focuses on specific challenges that are brought up repeatedly in the literature, such as getting people to stop burying the deceased, as this may spread EVD and to encourage them to visit a health center in the early stages of an illness to test for EVD. ‘Bylaws’ is as a concept to this dimension as the effectiveness of this intervention led by TLIs are debated (Boland and McKay, 2018; Enria, 2017; Parker and Allen, 2018; Parker et

al., 2019; Richards, 2016; Van der Windt and Voors, 2020; Wilkinson et al., 2017). The bylaws were introduced to correct some of the demand-side barriers as mentioned.

The bottom image shows two conceptual gaps in knowledge that the thesis will address in the orange hexagons. The first is institutional quality, using the extended definition as described above. This is the theoretical contribution of knowledge to the thesis. The second orange hexagon ‘polycentric governance’ is the evidence-based contribution, as these were observations formed through the informants’ narratives of how the outbreak was governed via multiple institutions.

Figure 4. Third Dimension in the Literature Review



In a public health emergency, behavior changes are needed to reduce the risk and the disease spread. These changes are to encourage (increase demand) community members to visit the hospitals or use safe hygienic practices. In this role, TLIs and community leaders have a part to play. Donors and humanitarians are often on the supply-side of the aid market, where they may bring medical equipment, build makeshift medical units, do training and capacity building, but often are not equipped to address any demand-related factors that limit uptake of such resource deployment, like rumors and misinformation that were documented during the 2014 Ebola epidemic (Ohlheiser, 2014; Phillip, 2014; Thiam et al., 2015). This does not mean they are unaware of the demand-side

barriers or do not try to address them but are limited in how to do this effectively. These information failures (rumors and misinformation) led to a social cost. In this case, the social costs are Ebola deaths, which depleted families and communities. These high social costs, in turn, were affecting local and national economies and production.

Primary data from the case study suggest that through rulemaking, monitoring, and enforcement, TLIs demonstrated high institutional quality by lowering social costs and fixing information failures in the market. By correcting these market inefficiencies, they helped to increase demand for health-related aid resources. TLIs in Sierra Leone passed bylaws to incentivize consumers to report sick persons to a health center and decrease 'risky' behaviors,⁹ such as prohibit funerals, blood rituals of the secret societies, personal contact, and movement. These were enforced by substantial fines. Community engagement efforts in Liberia also fixed information failures and some social costs, but informants say that aid resources also helped to reduce social costs by having health workers return to caregiving. Additionally, the same local strategies in Sierra Leone were scaled up as national emergency policies, where it was not coordinated everywhere in Liberia. These findings were based on the informants' interviews; thus, while there was not a strong narrative regarding the impact of aid by Sierra Leonean informants, it does not mean that aid did not benefit health workers.

The primary data are triangulated with the WHO's Ebola situation report. According to this report, Sierra Leone reported 14,124 total cases with 3,956 deaths and Liberia reported 10,675 cases and 4,809 deaths due to EVD during the entire outbreak period (World Health Organization, 2016a). Therefore, the EVD death rates in Sierra Leone was 28%, while in Liberia it was 45% of EVD cases, according to these figures provided. Sierra Leone identified more EVD cases than Liberia, at almost 4,000 more cases, but recorded nearly a thousand less deaths than Liberia (World Health Organization, 2016a). Thus, rulemaking and a bottom-up approach to nationalizing the local bylaws made a difference in Sierra Leone, where the epidemic was rural dominated and traditional leaders had a larger role in governing.

IV. Chapterization

This section provides a summary of the chapters in this thesis.

⁹ Quotes are used around the term 'risky' because these are not high-risk behaviors in normal times.

A. Chapter One

The first chapter is the contextual background of Sierra Leone and Liberia before the 2014 EVD outbreak. This includes their historical development broadly and healthcare systems specifically. Both countries were ‘founded’ for repatriated slaves from Britain, the Caribbean, North and South Americas, as well as free persons (including escaped slaves) (Frankfurter et al., 2018; Harris, 2012). However, political and economic construction differed with Liberia firmly consolidating Monrovia as a highly centralized seat of power that largely excluded the diverse indigenous ethnic groups in the interior (Harris, 2012). In Sierra Leone, the Krios, a term for the descendants of repatriated slaves, did largely stay in Freetown and the western area. However, the country operated as a British colonial protectorate where the paramount chieftaincy was manipulated to serve the colonial agenda, this included forced labor and taxes (Harris, 2012).

After the war, there was a large influx of Western-derived aid and developmental resources to rebuild state institutions and improve governance to ideally prevent another civil conflict. However, some scholars, such as Harris (2012), Mulbah (2018), Mustapha (2016), Pailey (2017), and Sawyer (2005a) argue that some of these reforms may not bring democracy and legitimacy to national governments. Official governance indicators from the World Bank (2017) show that both countries are operating under weak governance, however, this only reflects state institutions and not traditional ones. In terms of liberal economic and democratic performance, neither country is operating to the standards set by Western-derived experts.

This chapter demonstrates that good governance reforms were meant to create institutional change to state-run institutions and improve their institutional quality for economic growth. However, these policies have had mixed success. These development reforms do not always include traditional institutions, and thus, leave out this perspective of local development. Second, the health-related governance data show that the countries were improving on a few indicators, but this did not translate into a widespread improvement in the health infrastructure. Leaving both countries vulnerable to a disease epidemic.

B. Chapter Two

This chapter begins by examining the original framework of New Institutional Economics led by key thinkers North, Acemoglu, and Oström. What began as a theory to analyze economic history was then used in development policy, as this theory focuses on what changes make an economy grow, decline, or stagnate. Institutional quality is normally conceived as institutions that can protect private rights, enforce contracts, and keep transaction costs low (North, 2003). This would encourage people to cooperate and not defect (corruption or cheating). However, what is missing is how institutions can govern for social outcomes and use this to determine institutional quality.

Another branch of new institutional economics is the concept of polycentric governance, where institutions at the local, national, and regional levels collectively govern for public goods. This builds on Oström (1990; 2010)'s work where actors come together in collective action to prevent overexploitation of limited agricultural resources. This could be useful in helping us explain how multiple institutions governed the EVD outbreak.

The chapter engages in the debate on traditional institutions from various studies. Acemoglu, Reed, and Robinson (2014), Beekman, Bulte, and Nillesen (2013; 2014) Hanlon (2005), Jackson (2005; 2006), Mamdani (1996), Peters and Richards (1998), and Richards (2005) argue that traditional leaders tend to be despotic or corrupt. And, Adjei, Busia, and Bob-Milliar (2017), Fanthorpe (1998; 2001; 2006), Logan (2013), and Ubink (2008) say that these leaders still have popular legitimacy and rural-based constituents see a place for them governing in the modern state. The thesis holds that the literature supporting traditional chiefs tends to use cultural and religious identity as the main factors. However, these cannot be generalized as not all chiefs hold religious authority and culture is not the only aspect that defines and legitimizes them. The thesis fits into a third debate that does not argue for chiefdoms to stay or be abolished, but rather looks at how their governance impact social or economic outcomes, and if needed, how these may be reformed (Baldwin, 2015; Bulte, Richards, and Voors, 2018; Dia, 1996; Khan and Mehmood, 2016; Pande and Udry, 2005; Sesay, 2019; Unsworth, 2010).

The next two dimensions of literature are on public health emergencies and the 2014 EVD outbreak. These are critically reviewed in a power-laden context, using Scott (1992)'s concept of public and hidden transcripts. The public transcript is the dominant narrative that is accepted as mainstream and not often challenged. The hidden transcript

gives a narrative that rivals the dominant one and is not often accepted as mainstream. The dominant narrative is that donors and humanitarians typically respond in a disease outbreak to bring supplies and affect change in behaviors (demand-side barriers). This depicts community engagement and mobilization strategies as top-down and led by an external actor, such as an NGO. The narratives of how local groups self-organized are hidden transcripts.

The final dimension on the 2014 Ebola epidemic shows some public and hidden transcripts. Specifically, there are critiques of how traditional interventions were not penetrating the community to change 'risky' behaviors or engage with people. The standard biomedical information was not disseminated in a culturally and contextually appropriate way. A hidden transcript reveals that community and traditional leaders organized during this outbreak to correct demand-side barriers, and there is a debate on whether the eradication of EVD can be attributed to local efforts and not aid intervention.

C. Chapter Three

The third chapter discusses the qualitative methods used and how data were collected in the field. A qualitative methodology seeks to explore a phenomenon closely and in-depth. This comparative case study design was chosen as both countries exhibit close parallels in their histories and development trajectories, but the differences in some governance indicators made for an interesting comparison. As demonstrated in chapter one, Liberia was considered a model for post-conflict development after the war, however, both countries had difficulties identifying and containing EVD in the beginning stages of the epidemic.

The process of undertaking fieldwork is also discussed in detail: sampling, mapping, interviewing, field supervision, gatekeepers, and protocols on leaving the field so that future research is not hindered. Copies of the questionnaires used to collect data are in Appendix A. These strategies were used with the intent of seeking knowledgeable informants from diverse backgrounds. Ethics approval was obtained through the University of Westminster in 2016 and an amendment in 2017, consent forms and information sheets are in Appendix B.

Thematic analysis is used to structure the work into three broad themes of 'Government's Response and Community Reaction,' 'Local Institutional Intervention' and

‘Governance of the Outbreak.’ These themes were derived from coding through Nvivo version 11 software. The primary data (informants’ interviews) are triangulated with secondary data from the WHO. Triangulation is used in the manner described by Denzin and Lincoln (2005) for qualitative research, to demonstrate a reality through multiple angles.

Rigor and robustness of the research are discussed in section 3.7; specifically, what is meant by robustness in qualitative research, as opposed to reliability and validity in quantitative research. This section explores the key thoughts on producing high quality research and uses the criteria by Morse et al. (2002) to define the rigor and robustness of the findings. Namely, methodological coherence, sampling and saturation, data analysis, and theory development. An evaluative criterion of member checking was used after the research was completed. Gatekeepers gave feedback on whether the findings matched their lived experiences during the outbreak, these documents are in Appendix C. Finally, the chapter concludes with the limitations of the research project.

D. Chapter Four

This is the findings chapters. It contains the demographics statistics of the informants, then gives a baseline assessment of each countries’ healthcare system before the EVD outbreak. Then, the data are arranged thematically. The first theme, ‘Government’s Response and Community Reaction,’ discusses several information failures and social costs. Informants remember the beginning of the outbreak lacking clear information and protocols on diagnosing or handling potential EVD patients. They were simply told not to touch, but this is a paradox for caregivers, not to mention community members began to lose trust. Some health workers reported leaving the health centers or their facilities closing, another social cost.

The second theme, ‘Local Institutional Intervention,’ discusses how community and traditional leaders began organizing because of the belief of government incompetency. Some reported that when aid resources arrived in phase two, many health workers returned to the health centers to take care of patients and felt positive about donor interventions. However, some community stakeholders were less enthusiastic, reporting that NGOs and donors did not work with them nor supplied resources for

distribution. Some health workers also said that government and aid resources came too late.

The third theme, 'Governance of the Outbreak,' is a holistic view of how multiple institutions helped or hindered the response. There is a narrative of polycentric governance to address specific challenges (Oström, 1990; Oström, 2010), as no one institution was able to address supply and demand barriers. In Liberia, the governance of aid institutions supplying resources benefited health workers, and community organizing helped fix demand-side barriers. However, community organizing did not consistently happen everywhere with the same set of protocols. Some neighborhoods had checkpoints for isolation while others only did health education.

In Sierra Leone, TLIs governed to correct demand-side barriers by reducing misinformation and social costs. The supply-side of the intervention, such as equipment and medicine was challenging as local institutions do not control for this. Some reported that aid resources, such as contact tracing and health sensitization penetrated the communities because there was more cooperation. However, since this began in phase one of the outbreak, this could be referring to aid resources already present in the country or resources brought in by non-Western donors like China or Uganda.

E. Chapter Five

The final chapter is a discussion of the literature and findings to achieve the aims and objectives of the thesis. The first section is a synopsis of the informants' narrative of self-organizing. This builds on Hewlett and Hewlett (2008)'s observations of rural communities enacting emergency management regulations during an EVD outbreak. This achieves the first objective: determining how state and community responses differed. Then a critical discussion on how locally derived responses in health have received scant or negative attention.

The following section is a market approach of the 2014 EVD outbreak and details the various information failures and social costs that slowed containment of the disease. These market failures affected the demand for health services, including those provided by NGOs. Thus, this section fulfills the second research objective of identifying the challenges in EVD management and prevention and explains the theoretical contribution

to knowledge. The first and second sections achieves the first aim regarding the role of TLIs during the EVD outbreak.

The third section, 5.4 discusses the third theme of the overall governance of the response with multitier institutions. This builds on Oström (1990; 1998)'s and Sawyer (2004)'s concept of polycentric governance. Traditional and community-level institutions governed the demand-side of the market and aid and state institutions governed the supply-side barriers. This is the evidence-based contribution to knowledge, and it achieves the third objective regarding the informants' narratives of how the outbreak was governed.

The final section discusses the literature debate on community engagement during the 2014 EVD outbreak and its implication on aid and future disease outbreaks. It introduces the policy contribution to knowledge on how future epidemics can be governed through bilateral knowledge exchange. The controversy surrounding the bylaws and how the public transcripts (Scott, 1992) have perceived these efforts are critically discussed. It examines the secondary data from the WHO and interprets why EVD death rates were lower in Sierra Leone, due to a bottom-up nationalized community engagement effort to reduce social costs (EVD deaths). This section achieves the remaining objective (the literary discussion on the community's impact on aid) and both sections 5.4 and 5.5 answer the second research aim regarding community engagement and aid performance during a public health emergency.

The entire thesis consists of five chapters, excluding the introduction and conclusion. The appendices and bibliography are listed at the end of the thesis.

CHAPTER ONE:

The Countries' Context

The research is sensitive to the conditions surrounding the phenomenon of interest. This deepens our understanding of internal and external factors.

1.1 Introduction

The central question addressed in this chapter is: why were the health systems of Liberia and Sierra Leone so weak when the Ebola outbreak started, despite years of aid and post-conflict development? The countries were modernizing their overall infrastructure and delivery of services, including healthcare while battling widespread poverty. Sierra Leone's incidence of poverty as of 2010 was 60% (International Monetary Fund, 2011b) and Liberia stood at 64% during this same period (International Monetary Fund, 2011a). Reconstruction is largely financed by loans and grants that come with policy conditionalities (Guttal, 2005). Individual nongovernmental organizations (NGOs) or private entities are not equipped to address system-wide problems or even other medical conditions outside the scope of the donors' priorities. For example, both countries have private foreign firms providing health services for their workers. However, during the 2014 Ebola Virus Disease (EVD) epidemic, some companies continued operations and even made donations to humanitarian organizations (Knight, 2016; Rooney, 2014), but many companies suspended operations and left the country, taking their health resources with them (DW, 2014). Strategic planning and reliance on external resources may help fragile states provide 'interim' or 'basic' health services while governments build an infrastructure for a long-term solution (Keith and Cadge, 2010). However, these may not be dependable during a crisis or help implement system-wide changes. This is the context of post-conflict development and health in the case study countries, particularly their healthcare systems before the disease outbreak.

The discussion in this chapter is situated in the broader context of aid and health interventions, giving an understanding of the supply-side of the aid market. The first section briefly discusses aid and its terminology and evolution. This includes how aid became liberalized through 'good governance' policies of small government and privatization of resources. Then, it goes on to demonstrate how global health policies have been impacted by this. Section 1.3 discusses Liberia's history and development, and then Sierra Leone is discussed in the same fashion in the next section. Section 1.5 reflects on both countries and compares a few governance indicators. The final section, 1.6, is a brief introduction of the 2014 EVD outbreak in West Africa and challenges on the supply-side of the intervention.

1.2 Understanding Aid

Before examining the details of Liberia's and Sierra Leone's history, development, and healthcare system, it may be useful to first understand the supply-side of the aid market. This section explains what aid is, its purposes, how donors and humanitarian organizations choose to channel aid resources, and how they evaluate interventions or how the aid was governed by recipient countries. The thesis examines aid resources that are dispensed during a public health emergency. However, given the fragile nature of the case study countries' infrastructure, several types of aid resources were mobilized during the response. Learning these parameters will help to understand the demand-side challenges in the second and fourth chapters.

A substantive part of the literature has examined 'development aid.' Development aid aims to improve the socioeconomic conditions of recipient countries (Moyo, 2010). It accounts for most aid resources as the World Bank's International Development Association is one of the largest assistance programs (World Bank, 2018).

Aid has a long history that has evolved since World War II (Glennie and Sumner, 2016; Jaspars, 2018). For example, for decades, aid focused on capital expenditures such as building hospitals, schools, or donating vehicles, but not discretionary expenditures such as staff salaries. This changed after 2000, and included resources to strengthen systems; however, the proportion of this aid is small. At its basic conception, aid is the transfer of resources from one country to another. However, before the 1970s, effectiveness was not considered, because as an additional resource, aid was always assumed to be a positive contribution (Glennie and Sumner, 2016). Aid can correspond to cash transfers, research and development, direct investment, in-kind transfers, infrastructure, and capital projects, and the projects have different lengths, scopes, context, conditions, and goals. Its intrinsic nature is therefore highly varied (Glennie and Sumner, 2016).¹⁰

According to Fearon (2006), all aid that achieves humanitarian goals, such as poverty reduction or providing relief to refugees of a natural disaster or conflict, can be considered

¹⁰ The 2005 Paris Declaration of the Organization for Economic Cooperation and Development (OECD) and the 2008 Accra Agenda for Action were broad commitments to harmonize and align all aid delivery for effectiveness and to the priorities of recipient governments (Organization for Economic Cooperation and Development, 2008). However, there is a debate on how this is being implemented and if the recipients' agendas are really prioritized (Banerjee and Duflo, 2012; Booth, 2012; Hayman, 2009; Sjöstedt, 2009). Liberia became a case study for a dual-track funding strategy and long-term development assistance (Save the Children, 2009). Section 1.3 on Liberia's post-conflict recovery discusses this further.

humanitarian. Indeed, as Fearon (2006, p.3) notes, “[A]id from rich to poor countries for the purpose of promoting economic development is humanitarian aid in this ordinary sense.” However, there is an official distinction in the aid industry, where development aid and emergency relief are separate categories with separate funding streams. Therefore, humanitarian aid is, “the response to emergencies as opposed to attempts to improve the normal state of affairs,” (Fearon, 2006, p.4). Fink and Radaelli (2011) also make this distinction:

The main objective of ODA [development assistance] is the eradication of poverty and its principal causes, which implies considerable involvement of recipient countries in the negotiation and implementation of intermediate to long-term policies and projects. Humanitarian assistance, on the other hand, is meant to provide rapid assistance and distress relief to populations temporarily needing support after natural disasters, technological catastrophes, or conflicts, generally classified as “complex emergencies.” (Fink and Radaelli, 2011, p. 742).

Fink and Radaelli (2011) also say that development assistance is resources channeled through the state, while humanitarian aid is channeled at the community level.

Moyo (2010) classifies aid into three broad categories. ‘Humanitarian or emergency relief’ aid, which is quickly disbursed in times of disaster; and second, charity aid is released by organizations on the ground in the affected areas. Third, ‘systemic aid’ is paid directly to governments through either bilateral (government to government) or multilateral transfers (institutions, such as the World Bank, to government). In addition, there are also other sub-categories of aid, such as ‘food aid,’ which deals solely with supplementing nutritional needs (Jaspars, 2018). Emergency or humanitarian aid is dispensed for short-term relief, but sometimes, there are no clear transitions from short-term to long-term assistance, leaving a gap. Likewise, humanitarian assistance may be extended for long periods, like in a protracted war (Jaspars, 2018; Keith and Cadge, 2010). These distinctions are not always made clear in the literature. Sometimes aid is bypassed in states with weak governance for institutions with stronger governance, so it may also be non-state entities delivering services.¹¹ Sierra Leone and Liberia have had different types of aid, such as charity and relief aid provided by humanitarian organizations at the community level for decades and development aid acquired through complex bilateral and multilateral negotiations.

¹¹ The type of aid resources is determined by donors’ perceptions of institutions in the affected region. As mentioned in Keith and Cage (2010), fragile states with weak institutions can change donors’ preference on the type of aid to give or according to Dietrich (2013), channel aid resources through bypassing a weak government for private actors. See Acht, Omar Mahmoud, and Thiele (2015) and Dietrich (2013; 2016) for more on aid bypass.

Additionally, the providers of aid also have distinct terminology that is not always made clear in the literature or informant interviews. Broadly, there are ‘philanthropists,’ ‘donors,’ ‘funders,’ and ‘charities.’ However, for clarity in the thesis, the term ‘faith-based charities’ and ‘NGOs’ generally refer to humanitarian aid providers such as the Red Cross or Samaritan’s Purse. ‘Donors’ refer to government agencies, such as the United States Agency for International Development or International Finance Institutions (IFIs), such as the World Bank or International Monetary Fund (IMF). However, sometimes the literature and informants’ interviews use a different term like, ‘external partner or support,’ ‘aid resources,’ or ‘donors’ without specifying which type.

1.2.1 Aid Governance

Donors, Funders, and NGOs are concerned about their aid being effective and achieving the goals that were set. The question of how to effectively channel aid resources into low-income countries has challenged academics, philanthropists, and donors over the last three decades.¹² There have been numerous studies attempting to determine how aid is working or not working (Benes, 2017; Booth, 2012; Easterly, Levine, and Roodman, 2004; Farang et al., 2009; Gulland, 2014; Hayman, 2009; Sridhar and Batniji, 2008). The discussions have focused on policies, conditionalities,¹³ or decisions donors and organizations enforce to channel aid resources (Abbott, Andersen, and Tarp, 2010; Chhibber, Laajaj, and Bain, 2006; Dietrich, 2013; Dreher, Kotsogiannis, and McCorrison, 2009; Hayter, 2005; Hilary, 2010; Kersting and Kilby, 2016; Kilby, 2009; Stone, 2004; Vreeland, 2004).

However, for this thesis, we are concerned with the impact of aid to low-income countries and that is the phenomenon of ‘good governance.’ This has broadly shaped post-conflict development of Liberia and Sierra Leone and their health systems, and therefore, contextualizes how the health systems functioned before the 2014 Ebola epidemic and why it could not initially contain the disease outbreak.

¹² Governance is the pattern of rules or practices of governing (Bevir, 2016). It is normally applied to understanding the power of the state. However, it can refer to a system where a state is dependent on, such as the UN. Therefore, there is international or global governance or global health governance by the WHO. See also Bevir (2012).

¹³‘Conditionality’ is an agreement for development loans if the borrower (a) maintains an adequate macroeconomic framework, (b) implements its overall program in a manner satisfactory to the World Bank, and (c) complies with the policy and institutional actions that are deemed critical for the implementation and expected results of the supported program (World Bank, 2005, pp. 3-4).

Tirman (2005) says that policies of good governance and small government intended for economic growth, which may subsequently bring health and education development, lack economic sense. For example, the Structural Adjustment Program (SAP) in the 1980s and 1990s encouraged privatization of state assets such as hospitals. This negatively impacted socioeconomic development. This era in aid is called the Washington Consensus.¹⁴ According to the World Health Organization (WHO), the SAP has affected the supply and demand for health services, slowing improvements or even worsening the health statuses of people in these countries (World Health Organization, 1995; World Health Organization, 2017b). It mandated that recipient countries of foreign aid make macroeconomic changes to their economy and government, such as privatizing state enterprises and devaluing national currencies. Also, it required countries to join free trade agreements that usually disrupted the agriculture sector by having local farmers compete with large corporations (Bromley, 1995; Simms, Rowson, and Peattie, 2001).

Reforms suggested by the IFIs are meant to improve state institutions in developing countries. The 2002 World Development Report discusses strategies to build institutions for market efficiency and productivity. The report says the state is to provide institutions to support a market economy and if a state can do so successfully, it has 'good governance':

Good governance includes the creation, protection, and enforcement of property rights, without which the scope for market transactions is limited...And it includes the provision of sound macroeconomic policies that create a stable environment for market activity. Good governance also means the absence of corruption, which can subvert the goals of policy and undermine the legitimacy of the public institutions that support markets. (World Bank, 2002, p. 99)

The era of the post-Washington Consensus is said to expand development policies beyond economic growth to include social issues such as health, education, gender equality, and peace. Donors also encourage recipient countries to 'own' development projects by writing Poverty Reduction Strategy papers (PRS) (Mathews, 2007). In 1999, the IFIs created the PRS to address criticisms of the SAP (Navarro, 2007). However, the PRS was aligned to the 2015 Millennium Development Goals (MDGs), which is a United Nations (UN) endeavor and not specific to each country's needs. The conditionalities still exist on concessional loans and often, recipient countries are asked to privatize and reduce government spending (Bayliss and Cramer, 2001; Birdsall and Fukuyama, 2011). Harris (2013) succinctly says that

¹⁴ This era is called the Washington Consensus, partly because the IFIs are in Washington D.C., but also because the strategies are based on a neoliberal economic ideology as Tirman (2005) describes. These were recommended for recipient countries of aid without always considering the local context.

the Washington Consensus of the 1980s and 1990s saw the state as part of the problem, whereas in the post-Washington consensus it is part of the solution. However, even in this recent era, recipient governments of aid still have to reform to the liberal economic ideology of small government and free-market institutions.

Recipient countries of aid have had their healthcare systems largely defined by three health-related MDGs: eradicating HIV, Malaria, and Tuberculosis, reducing childhood mortality and reducing maternal infant mortality (MMI).¹⁵ The effectiveness of aid resources was determined by these performance-based indicators, largely supplied by vertical interventions. As for the supply-side of health –related aid resources, the liberalization of aid has also affected the global health platform and how providers supply health interventions into low-income countries. This is discussed in the next section.

1.2.2 Health as a Human Right

The declaration of the 1978 Almá Atá Conference under the WHO and the United Nations Children’s Fund sponsorship was agreed by 136 countries to bring universal primary healthcare (World Health Organization, 1978a). Then there was the Universal Declaration of Human Rights to grant access for health to all by 2000. All countries, except for Somalia and the United States, were signatories on this declaration (Hall and Taylor, 2003; Kaplan and De Carmago, 2016; Kickbusch, 2005; Meier and Onzivu, 2014). The right to health was to be achieved through the principles of the Almá Atá declaration which focused on equity and engagement of communities. However, the timeline for Universal Health Coverage (UHC) has passed and not all countries achieved this. Primary healthcare principles were not implemented due to global investment in targets, instead of health systems more broadly; and investing in economic growth as opposed to broader socioeconomic issues (Werner and Sanders, 1997).

¹⁵ There are 15 MDGs and three are health-related goals. MDG 4 was to combat childhood mortality (defined as under age 5). MDG 5 was to decrease maternal and infant mortality (defined as 1 year or younger) and MDG 6 was to combat HIV/AIDS, Malaria, and other infectious diseases (United Nations, 2015). However, most resources went to HIV/AIDS, Malaria, and Tuberculosis. The MDGs were an aggregation of global trends condensed to specific targets to be achieved by 2015. Therefore, the numerical targets were set in line with global trends since 1990, and not based on actual trends for any region or country. For example, the HIV/AIDS target was guessed, since there was no actual tracking of infection rates beforehand. Additionally, Asia had been reducing poverty and MMI rates since the 1990s, and the MDGs reflect the progress that they had already been making. However, in sub-Saharan Africa (SSA), poverty and MMI increased between 1990 and 2001. These articles ask whether SSA is missing the targets for the MDGs or are the MDGs not well-targeted for SSA (Berg and Qureshi, 2005; Vandemoortele, 2008). The Sustainable Development Goals came after the MDGs to continue tackling poverty. However, since this came after the outbreak it is not discussed in this thesis. See Lim et al. (2016) on this new agenda and Smalle (2017) on issues of implementing these goals in Sierra Leone.

There are multiple perspectives on how health should be prioritized on the global agenda, and these perspectives can encompass a wide net of actors and stakeholders (Bond, 2008; Dodgson, Lee, and Drager, 2002; Fauci, 2007; Horton and Lo, 2014; Iwelunmor and Airhihenbuwa, 2013; Kay and Williams, 2009; Kickbusch, 2005; Kickbusch, Silberschmidt, and Buss, 2007; Koplan et al., 2009; Lee and Brumme, 2012; Lee and Kamradt-Scott, 2014; Parks, 2014; Picazo, 2014; Poku and Whiteside, 2002; Ruger, 2005; Smith et al., 2003; Vineis, 2017). These sources agree that the WHO is the lead international agency on all health matters, at least on paper. However, aid for health interventions in low-income countries has been dominated by other organizations, companies, charities, and individuals,¹⁶ such as the emergence of public-private partnerships with pharmaceutical companies and research institutes. These partnerships have ethical dilemmas as they place profits above human rights. Some of these companies have more financial resources at their disposal than the WHO's annual budget (Bluestone, Heaton, and Lewis, 2002). In this sense, the WHO is a humanitarian organization with different missions and values than for-profit businesses.

1.2.3 From Human Rights to Cost-Effectiveness

Some argue that other organizations are shaping the global agenda on health, while the WHO's capacity has waned (Frenk and Moon, 2013; Lidén, 2014). One donor that is discussed frequently is the World Bank, as it is the main provider of concessional loans to low-income countries (Picazo, 2014; Poku and Whiteside, 2002; Ruger, 2005). These loans, as part of the PRS, were often used for the narrowly defined health goals in the MDGs.¹⁷ While there are other sources of aid, such as humanitarian aid for health and could provide broader health services; these are much smaller than the funding received from IFIs. Poor countries carry the global burden of 10 infectious diseases and aid for these few diseases has impacted domestic health policies and service delivery (Bluestone, Heaton, and Lewis, 2002; Chu et al., 2014).

¹⁶ As recently as the 2018 Astana Declaration, the principles of the *Almá Atá* declaration continue to be reconfirmed (World Health Organization, 2018d). However, some issues, such as equity, have been overlooked in the implementation of programs.

¹⁷ Although World Bank loans are aligned with the PRS, the bank has been influencing health policies since the early 1990s. It created a report that focused on the economic impacts of health by preventing the "economically productive" population from getting sick (human capital), this encouraged many countries to focus on these "priority illnesses". See Picazo (2014), Ruger (2005), and World Bank (1993).

Another example of the shift in health as a universal right to a neoliberal ideology is the 2000 G8 summit.¹⁸ This convention invited Algeria, Nigeria, Senegal, and the WHO for the first time; this is significant because the G8 had not discussed health or health as a development issue before this (Schiffes, 2005). According to Kurokawa et al. (2009), a strategy was created to combat health conditions that cause and perpetuate poverty. This was followed up with statements made by G8 leaders on the critical importance of health within the context of strategies for poverty reduction (Bruntland, 2001). Although the Director-General of the WHO at the time, Gro Harlem Bruntland, was encouraged by the renewed efforts of researchers, developing nations, and activists in the health-for-all-movement, couched within these statements was the ideology that had been shaping global health governance (GHG)¹⁹ from the human rights-based model to one of cost-effectiveness and short-term goals. For example, Bruntland (2001)'s statement discussed making globalization work for the poor through public-private partnerships with research institutes and pharmaceutical companies to create more drugs and vaccines, combating infectious diseases, and working with international trade laws. This does not specifically say aid; however, it is referencing the same ideology of a free-market approach in health.

Thus, donor pledges to fill the gap in the healthcare system have been clinical interventions that are cheap and easy to administer. This is opposed to broad horizontal interventions to target the underlying social and economic conditions of the community (Harman, 2015; Kickbusch, 2005). This is termed the 'social etiology' of health, which examines health status beyond the absence of disease (Kelman, 1975). This includes factors like living conditions, environment, nutrition, and education. Kelman (1975) is critical of the neoclassical economic view on health as 'human capital' or earning capacity. He argues that this conceptualizes health as building a productive workforce. This concept later appears in

¹⁸ The G8 is an intergovernmental political forum led by the world's highly industrialized economies: Canada, France, Germany, Italy, Japan, Russia (until 2014), the United Kingdom, and the United States (Waterfield, Dominiczak, and Blair, 2014). There is no formal administrative structure or offices for members, like in the WHO or UN. The presidency rotates among members and a range of topics of mutual or global concern are discussed at the meetings (Laub, 2014).

¹⁹ Global Health Governance has many definitions and terms including global governance for health and governance for global health, each denotes levels of involvement in health activities. For instance, the WHO has an explicit mandate to govern health, so it falls in the GHG category; global governance for health refers to an institution that does not have a mandate but impacts health regardless, such as the World Trade Organization and trade policies on drugs. See Kickbusch and Cassar Szabo (2014), Lee and Kamradt-Scott (2014), and World Health Organization (2016g) for definitions. For more on trade policies and health see Bluestone, Heaton, and Lewis (2002), Cheru (2002), and Shadlen (2007). GHG is used throughout the thesis as a general umbrella term for governing health at the global level.

some development policies with quantifiable indicators, such as the DALYs²⁰ and the MDGs, where aid was directed at diseases that primarily affect males between the ‘productive’ ages of 15 and 49 (e.g. HIV/AIDS). However, these specific health conditions may not reflect the health needs of the broader population (De Waal, 2003; Johnston, Deane, and Rizzo, 2015; Parks, 2014).

A well-known example of the outcomes between health and development aid policies are interventions for HIV/AIDS. Many countries had to show ownership of development projects by writing a PRS paper, and there were very few health-related causes that international donors would fund, such as the MDG number six (HIV/AIDS). So, many recipient countries of aid had resources to address HIV/AIDS, but not other health problems such as diabetes or malnutrition. The political economy of HIV is briefly discussed below.

1.2.3.1 HIV/AIDS Intervention as an Example

According to Harman (2015), HIV/AIDS²¹ initiatives in Africa have been centered on ‘positive progress’ and high-profile campaigns where the ‘results’ get lost. However, the discourse of ongoing progress is necessary to maintain donations. While it is unrealistic to assume that a strategy will succeed on its first try, the ongoing discourse of ‘positive progress’ (usually backed by data showing the measured targets or performance-based indicators) hides the real results of health disparities and socioeconomic inequalities (Harman, 2015). And, as money flows in, it creates a distortion in a country’s health sector, as health policy and planning are centered on HIV services rather than the general needs of the population. The resources poured into specific health initiatives, termed vertical interventions, discriminate against people with other illnesses and conditions.

This is an example of how donor-sponsored initiatives negatively impacted the poor. In general, vertical interventions separate the specific disease or condition from the

²⁰ The Disability-Adjusted Life Years (DALYs) was introduced by the World Bank’s 1993 report. It is an econometric tool to determine which disease burden is hindering economic growth but redefined its stance on access to healthcare. It acknowledges that governments can not provide all services to everyone, but that the market approach to exclude the poor was also bad. Therefore, major disease burdens should be prioritized, and services provided to the general population based on these priorities (Chorev, 2013; Parks, 2014; World Bank, 1993).

²¹ HIV stands for Human Immunodeficiency Virus and it is the virus that causes AIDS: Acquired Immune Deficiency Syndrome. While it is sometimes used interchangeably or without distinction, these are two different things. The virus (HIV) damages the immune system to weaken it. However, with today’s medical advances, one can be infected with the virus (i.e. HIV positive), but not have the immune system severely weakened. If it does become severely damaged to where even a minor infection such as a cold is life-threatening, then this is AIDS (Cobo, 2014; Whiteside, 2008).

generalized health crisis of the society (Mustapha, 2006). This separation is due to donor institutions²² focusing on fiscal performance and not social outcomes. In other words, the policies focus on the clinical and medical side of disease intervention and not the social etiology of disease. Thus, in health interventions, the supply-side of the aid market tends to focus on bringing clinical resources for quantifiable results and does not always address the demand-side barriers.

This is in part because the econometrics favored at the time did not measure social determinants. For example, in prevention-oriented strategies such as condom distribution, perinatal testing and drug treatment, and (in very few places) needle exchange programs, only what Johnston (2015) calls “bad behaviors” are analyzed, whilst issues surrounding power, poverty, and ecology of HIV/AIDS are ignored. Additionally, these programs use performance-based indicators (e.g. how many condoms were given out, how many pregnant women tested...etc.) which gives quantifiable results. While this specialized market has changed over the years to increase the number of people who can access services (HIV and sexually transmitted infections, HIV and Cancer, HIV and nutrition...etc.), social and political determinants are often not addressed.

This section briefly discussed the supply-side of the aid market, and specifically, health-related aid resources. There are many challenges and factors that donors and humanitarians contend with to deliver aid, along with competing priorities. Sections, 1.3 and 1.4 discuss the case study countries and their outcomes under these development interventions. Each section introduces a brief history and the conflict period, and then applies this knowledge of aid interventions to their post-conflict recovery.

1.3 Liberia

Liberia did not follow the same pattern of colonialism and independence as other countries in Africa and Asia. It was ‘founded’ as a settlement for repatriated American slaves whose descendants are called Americo-Liberians (Bøås, 2009; Harris, 2012). The American Colonization Society, which was founded in 1816 and funded by abolitionists and prominent politicians, sent free African Americans to Monrovia. It was believed they would live a better life there rather than face legal and social discrimination in the United States. The Americo-

²² It is not specified in this literature whether the term ‘donors’ exclude or include NGOs and humanitarian agencies.

Liberians brought Western culture to Monrovia (a republican political system and Christianity) and virtually intermarried within their community. This minority ethnic group became the governing elite and the affairs of the indigenous Africans were largely ignored and not included (Harris, 2012). Today in 2020, only two of Liberia's presidents come from an indigenous ethnic group (there are 16 ethnic groups in Liberia): Samuel K. Doe, who gained power through a bloody coup d'état in 1980, and current President, George Weah, who succeeded President Johnson-Sirleaf in the 2017 general elections.²³

Liberia evolved from a commonwealth of various Americo-Liberian settlements to a centralized state with Monrovia as the seat of power in the 1800s. It was the first country in Africa to declare its independence in 1847, and the second free Black republic, after Haiti (Office of the Historian, 2016). According to Harris (2012), before the civil war, the country experienced an economic boom in the 1950s and 1960s. However, this did not translate into widespread socioeconomic development; by 1960, less than 10% of the population in the rural counties was literate. By 1970, over 70% of businesses in the country's major trade industries were foreign-owned and political power belonged to a one-party state, led by the True Whig Party. This party was dominated by the Americos from 1884 until 1980, the moment of Doe's coup (Harris, 2012).

1.3.1 Conflict and Aftermath

Liberia fell into civil war from 1989, until Charles Taylor ascended to the presidency in 1997. Taylor led the National Patriotic Front of Liberia in the fight against President Doe's government (Harris, 2012). While violence slowed down intermittently, it did not really end, and the unrest escalated again from 1999 until 2003. President Taylor was also accused of war crimes in Liberia and for his involvement with neighboring Sierra Leone's civil conflict (Bøås, 2001). The twenty years of conflict had devastated the infrastructure and communities. This generation had lived longer under violence rather than living under a functioning government, civil service sector, education, and healthcare system. In 2003, Liberia and the international community, led by United Nations Mission in Liberia, created an interim government called the National Transition Government of Liberia (NTGL) and

²³ Presidents Charles Taylor (1997-2003) and Ellen Johnson-Sirleaf (2006-2018) are of mixed ethnic heritage, but were raised and socialized in an Americo-Liberian environment.

issued its economic governance plans, The Governance and Economic Management Assistance Program (GEMAP) (Bøås, 2009).

Bøås (2009) says this was essentially a 'trusteeship' approach to governance. The NTGL was manufactured by the international donor community, without considering how the previously warring factions would come together and govern. Some elitists may be implicated for their involvement, such as former President Johnson-Sirleaf, who supported Taylor's rebellion in the early 1990s (Harris, 2012). However, they are rarely brought to justice and are often included as the solution for peace and rebuilding. Therefore, when it comes to the International Criminal Court pursuing those for war crimes, justice can sometimes be unclear (Harris, 2012). In 2005, Ellen Johnson-Sirleaf was elected president in the country's first post-conflict elections and had to balance Western donors' and experts' expectations with the local political elite and Liberian citizens, including the indigenous ethnic majority (Bøås, 2009; Harris, 2012). GEMAP inserted international experts in key advisory positions throughout President Johnson-Sirleaf's administration for at least three years. Liberia, or specifically the Bank of Liberia (the trustee), had every economic and operational decision signed off by an expert who was chosen by the IMF (Bøås, 2009). However, with little negotiating power, Liberia had to accept these terms, especially as the fragile state needed foreign development assistance to recover and rebuild.

1.3.2 Post-Conflict State-Building

Many authors discuss the challenges of bringing a liberal democracy to Liberia as part of its post-conflict development (Harris, 2012; Kieh, 2017; Mulbah, 2018; Nyei, 2014; Pailey and Harris, 2017; and Sawyer, 2005a). Sawyer (2005a) says that elections have been controversial and trigger violence because of the zero-sum nature of Liberian politics. Harris (2012) says elections were held as part of the peace agreement after the war, but elections do not signify a shift or adoption of democratic values or institutions. Indeed, Kieh (2017) argues that the Johnson-Sirleaf administration adopted a hybrid governance system of authoritarianism and democracy. If its grip on power was threatened, it curtailed civil liberties in the name of security. And Pailey and Harris (2017) say that only half of Liberians feel their country has a strong democracy or one with only minor problems. Elected and appointed positions are often seen as a gateway to accumulating personal wealth and Johnson-Sirleaf's administration was no stranger to allegations of corruption.

Although good governance reforms such as GEMAP were implemented, there were long-standing structural issues that made the decentralization of power difficult. Liberia has several administrative and local units such as counties and districts and an appointed superintendent for each county. Nyei (2014) argues that these local divisions did not redistribute power and decision making, but rather acted as apparatuses for the central government to function:

Reforms after crises are targeted at ensuring good governance of the public sector and creating effective regulatory mechanisms for the private and non-profit sectors. Good governance itself is often a catchword in contemporary development discourse. (Nyei, 2014 p. 1)

The 1986 constitution had entrenched such a powerful central government that it made decentralization difficult after the war. For example, the role of the county superintendent is an anomaly to good governance reforms, because this is not an elected official, but rather someone appointed by the president of Liberia. This role does not have a relationship with other line ministries or with service deliveries (Nyei, 2014). Additionally, chiefs and clan leaders were gradually merged into the state and became agents of the centralized government, enforcing the laws created in Monrovia (Nyei, 2014).

Pailey (2017) says that vertical state-building in Liberia has been an internationally-driven development policy focused on legitimizing state institutions through neoliberal macroeconomic reforms. Therefore, this ignored non-state institutions or even undermined local political solutions to development, or in this case, the 2014 Ebola epidemic. Likewise, there is also a call to caution between internal and external validity and presumptions on reforming or introducing institutions for economic growth (Adam and Dercon, 2009). Adam and Dercon (2009) ask whether development practitioners should examine if existing institutions are there for a good reason, as opposed to automatically changing everything to mirror Western states. Thus, it is useful to briefly examine Liberia's local non-state institutions in this section, however, we will discuss rural institutions further in chapter two, where the theoretical framework is laid out.

1.3.2.1 Non-State Actors

According to Logan (2013)'s analysis of a multi-country 2008-2009 Afrobarometer survey, chiefs and clan leaders enjoy extensive popular support. In Liberia, 60% of respondents said traditional rulers had an important part in modern society and 58% said that these leaders should play a bigger role. In a 2014-2015 Afrobarometer survey, 49.8%

say they trust traditional leaders a lot/somewhat but only 30.1% said the same about the President (Afrobarometer, 2019).²⁴ This supports the argument that vertical state-building policies do not always bring legitimacy, including the holding of elections (Harris, 2012; Mulbah, 2018; Pailey, 2017). Traditional leaders enjoy popular legitimacy, even among both genders (Logan, 2013). Logan (2013) says this could reflect the conservative attitudes of women. However, the author did not consider that Liberia has traditional institutions for women too: secret societies. This is where women organize and can climb the ranks for social status and power (Moran, 1989). Thus, local institutions do not leave out women as there are also designated spaces for them. They are discussed as part of community engagement efforts in chapters two, four, and five.

1.3.3 Rebuilding the Healthcare System

By 2003, 354 of the 550 health facilities that existed before the war were functioning, and about 80% of those were operated by an NGO or faith-based charity; the clinical workforce measured at 3,100 persons, including private and nonprofit staff (Lee et al., 2011). The greater economy had an annual government revenue where spending on public services was at about \$25 dollars (USD) per person (Lee et al., 2011). President Johnson-Sirleaf's administration announced a suspension of user fees for those accessing the health facilities in 2007 (Meessen et al., 2011; Yates, 2009).

The introduction of the 2007 Basic Package of Health Services (BPHS) was a dual-track design where government efforts would not duplicate where external partners were already funding services (Meessen et al., 2011). The BPHS was one component of the National Health Plan and delivered maternal and newborn health from antenatal care to postpartum and newborn care; child health services that included expanded immunizations, childhood illnesses, and infant and young child feeding; also, reproductive and adolescent health, which targeted HIV and other sexually transmitted infections (Government of Liberia, 2011). It targeted the major disease burdens as defined by the WHO, and maternal, infant, and childhood mortality rates. The administration increased health human resources (HRHs)²⁵ by using off-budget funding to employ workers and get around the employment

²⁴ There are tables in section 1.5 from the 2014-2015 Afrobarometer survey comparing both countries before the end of the Ebola epidemic.

²⁵ 'Health Human Resources' or 'Human Resources for Health' refer to the health labor force, from frontline and support workers to managerial staff (World Health Organization, 2006; World Health Organization 2016h). The thesis focuses on

ban instituted by the World Bank and IMF conditionalities that restricted funding for government personnel (Varpilah et al., 2011). However, by 2008, Liberia was very dependent on external funding (80%) and the provision of health services presented challenges and competing priorities (Kruk et al., 2010). In addition, mental health and emergency care services were part of the BPHS, but not fully integrated. Kruk et al. (2010) say that the government's goal of having 70% of all health facilities offering all BPHS services by 2010 was unlikely.

The Liberian government, donors, funders, and humanitarian partners worked together from 2006 to 2009 to rebuild the healthcare system and maintain access to services (Newbrander, Waldman, and Shepherd-Banigan, 2011). Thus, with donors supporting humanitarian agencies to deliver services, the Ministry of Health and Social Welfare (MHSW)²⁶ was able to focus on long-term strategies such as training and accreditation of schools. The four components of the National Health Plan - which included the BPHS, human resources, infrastructure, and support systems - was the framework used to align stakeholders with national priorities (Newbrander, Waldman, and Shepherd-Banigan, 2011). So, health interventions were led by MHSW. Liberia was one of the top ten countries for infant mortality from 2000 to 2010 (Lawn et al., 2012), but infant and childhood mortality (MDGs 4 and 5) had dropped significantly by 2010 (World Health Organization, 2012b).²⁷ However, non-MDGs health services, such as mental health mentioned above by Kruk et al. (2010), were not well integrated or targeted.

The Liberian health sector pool fund was created in 2007 and it was one of the first of its kind. A state ministry oversaw health priorities, directed county health teams, and coordinated dozens of NGOs in the country (Abramowitz, 2014). According to Abramowitz (2014), the fund came with a mandate to decentralize the health sector as part of the country's overall democratization reforms. However, the structure of MHSW was still very bureaucratic and hierarchical; except for directors and program managers, all senior-level employees were appointed by the President (Nyenswah, Engineer, and Peters, 2016). The chain of command would start with a director or manager to the assistant minister of a

direct care staff, but support staff, such as security workers and cleaners at the health centers were also exposed, infected, and some died from EVD during the outbreak.

²⁶ The ministry restructured and changed its name after the 2014 Ebola outbreak to Ministry of Health, but MHSW is used in the thesis to prevent confusion with other health ministries (*An act to establish the Ministry of Health 2015, 2016*).

²⁷ This is shown in tables 1.1, 1.2, and 1.3 in section 1.5.1.

division, to the deputy minister of a department, then to the minister of MHSW, and then the President. According to Nyenswah, Engineer, and Peters (2016), this made it less efficient, limited engagement with stakeholders, and made it difficult to assume leadership during a crisis. Additionally, there were challenges with supply chain management in community-based services. According to Miller et al. (2018)'s study, the persistent stock-outs of drugs had resulted in community health services stopping in three out of the four study districts before the Ebola outbreak. This situation was more severe than in Guinea and Sierra Leone in this same study (Miller et al., 2018).

A study conducted in rural Nimba County of northern Liberia showed that, as of 2015, about half of survey respondents were not confident they could obtain health care if needed (Svoronos, Macauley, and Kruk, 2015). This study shows that prior experience with formal healthcare correlated with the confidence of obtaining healthcare, rather than proximity to facilities or quality of medical equipment. The poor and less educated had less confidence in the formal health sector meeting their needs. Thus, even though Liberia had secured a funding pool and chose its priorities, there were still demand-side challenges in getting consumers to access care. According to the MHSW 2011 to 2021 strategy, the healthcare system was not responsive or results-oriented due to low utilization and anecdotal evidence of the low quality of care (Government of Liberia, 2011). Service decentralization was proposed as a solution, but no goals or plans were stated. In terms of financial constraints, facilities are funded by government block grants and not performance-based funds. Therefore, services are facility-oriented rather than tailored to the needs of the local population. Additional revenue sources such as sin taxes²⁸ or piloting of social health insurance plans are suggested but these were not implemented nationally before the 2014 Ebola epidemic (Government of Liberia, 2011).

Thus, there were integration problems as external partners do not always work with county health teams, opting in favor of vertical interventions and thus, creating a parallel healthcare system. Before the Ebola outbreak, there were thousands of community health volunteers and development committees made up of trusted local leaders and peers to conduct community health services, such as administer Vitamin A and deworming

²⁸ Sin taxes are state-sponsored taxes to discourage the consumption of vices such as tobacco, alcohol, or gambling. The use of these goods or services bears a social cost on society and thus generating revenue this way can also off-set this cost. Social cost is discussed in chapter two, see Becker and Becker (1997) and Reubi (2016) for further reading.

medication (Bedford and Miller, 2017). However, Bedford and Miller (2017) report that MHSW says that these projects are largely led by external partners and receive little support from the ministry. This could lead to implementation problems as found in Petit et al. (2013).

This study of the BPHS found that limited engagement between health workers and policymakers posed this challenge (Petit et al., 2013). In interviews with health workers, they find that the low uptake of sexual and reproductive health services was due to demand-side barriers related to sociocultural challenges in the community and the role of traditional midwives.²⁹ However, policymakers attributed this to supply-side factors, resulting in asymmetrical policy planning. Policymakers focused on expanding the list of BPHS services offered, instead of addressing poor working conditions and constraints with the health workers to improve the services already offered (Petit et al., 2013).

This also presents a conundrum in medical humanitarianism, as there can be a gap between the community's needs, front line workers, and NGO decision makers. In Abramowitz (2015)'s research on Médecins Sans Frontières (MSF)'s withdrawal from three major Liberian hospitals, demonstrates that NGOs operate sovereignly from the health system. They often make decisions irrespective of the health consequences, local needs, or sentiments, especially if they perceive that their mandate has ended. A hasty withdrawal or "turnover" to MHSW could result in a gap in health services if development aid is not yet in effect.

1.3.4 'Good Governance' in Liberia

President Johnson-Sirleaf's administration had succeeded in promoting Liberia as a model for post-conflict development, with advancements in health and governance indicators, at least on paper (Nkwanga, 2015). It was heralded as making the greatest progress in its health status as it had the highest increase of life expectancy in the world of 19.7 years from 1990 to 2012 (Nkwanga, 2015, World Health Organization, 2014b).

²⁹ Traditional midwives, also known as traditional birth attendants (TBAs), tend to be older women in the community who assist mothers before and after pregnancies. Initially, there was a policy to integrate TBAs into primary healthcare policies (World Health Organization, 1978b); however, these traditional healers were partly blamed for high MMI rates. There has been a movement to make pregnant women deliver in a health center with a "skilled birth attendant" (Dodgeon, 2010). However, there is a debate on how this impacts rural women and access to healthcare; see Chi and Urdal (2018), Choguya (2015), Rishworth et al. (2016) Rudrum (2015). At the time of fieldwork, Sierra Leone and Liberia had laws banning at-home birth, which criminalizes the work that these women do.

According to Keith and Cadge (2010), this progress was due to political commitment and leadership from the President's office, Ministry of Finance, and MHSW for promoting and coordinating partnerships between donors, national and international NGOs, charities, and the returning Liberian diaspora. And, according to a UNAIDS report, Liberia had 30,000 people living with HIV/AIDS as of 2013 and has had a significant decline in AIDS-related mortality since 2005 (UNAIDS, 2018a). Between 2003 and 2011, Liberia halved infant mortality rates despite having fewer than 0.2 HRHs per 1000 persons (Keith and Cadge, 2010). When user fees were dropped, the government had 4 million USD to run the healthcare system and weak capacity as mentioned, because much of the health infrastructure was destroyed during the war (Keith and Cadge, 2010). The 2007 national health plan also committed to spending 15% of its national budget on health, which was in line with the Abuja Declaration of 2001 (Lee et al., 2011). Keith and Cadge (2010) say that these commitments amounted to an investment of 20% of its national budget into the healthcare system. Thus, before 2010, Keith and Cadge (2010) and Newbrander, Waldman, and Shepherd-Banigan (2011) believe that Liberia had a horizontal strengthening of its health system.

Johnson-Sirleaf's first term in office had economic growth rates up to 8% per annum and 16 billion USD of foreign direct investment, but 64% of Liberians live below the poverty line (Pailey and Harris, 2017). Transparency International credited Liberia as achieving "remarkable progress in the fight against corruption" (Chêne, 2012) since 2003. This was the result of the combined efforts of the international community, specifically GEMAP, which helped to promote accountability, transparency, and responsibility in key areas of the country's governance, according to Chêne (2012). However, President Johnson-Sirleaf has publicly said that the experience of GEMAP is mixed, it helped to address some issues of financial mismanagement, but it did not integrate well into other sectors (Government of Liberia, 2007).

1.4 Sierra Leone

Freetown, the capital of Sierra Leone, was initially a colony 'founded' by British abolitionists, freed and escaped slaves, and poor Black individuals whose descendants are called Krios (also the national language). The Krios' influence and power never really

extended outside of Freetown. The southern and eastern parts of the country are heavily dominated by the Mende ethnic group and the Northern area is dominated by the Temne and Limba ethnic groups (Harris, 2012).

Sierra Leone was a one-party state, which its leadership used a clientelist system to stay in power (Allen, 1995; Harris, 2012). From 1968 to 1992, the All People's Congress (APC) party ruled; it was founded by the country's first prime minister and then president, Siaka Stevens, who personally ruled until 1985 (Harris, 2012). Many working in government positions came from the same regional or ethnic group as the party leaders in power. Allen (1995) describes this clientelist model present in some African countries with strong centralized executive branches; however, ongoing corruption and spoils politics led to the breakdown in the state and military intervention in Sierra Leone.

The country had to transform from a 'big spending state' to a small liberal government when its economy collapsed in the late 1970s (Williams, 2004). According to Mustapha (2006)'s research of Sierra Leone and Uganda, retrenching the state in developing countries had significant impacts. The introduction of administrative reforms via the IMF's SAPs exacerbated an already declining economic condition under Stevens' administration. The SAPs led to layoffs of educators, healthcare workers, and other administrative professionals, and the private sector was neither able to absorb this workforce nor deliver adequate services where the state had rescinded its support (Mustapha, 2006; Zack-Williams, 1999). By the 1980s, APC supporters in public positions were laid off and President Joseph Momoh lost favor within his network, leaving him vulnerable for a coup d'état (Allen, 1995).

These reforms also meant that professionals had their savings shrunk as the country devalued the currency. Thus, with social and economic inequality rising, a black market and smuggling arose in the border towns of Sierra Leone, which in turn created political and security concerns. Mustapha (2006) says the rebellion which launched and brought the country into conflict in 1991 was a result of these conditions.

1.4.1 Conflict and Aftermath

The Revolutionary United Front (RUF) was formed in 1991. This was a rebel force mainly made up of youths and supported by President Taylor's National Patriotic Front of Liberia. It launched a rebellion to overthrow President Momoh (Harris, 2013; Human Rights

Watch, 1999). The RUF recruited children, villagers, and those in refugee camps, sometimes through coercion. A South African mercenary group, Executive Outcomes, was hired in 1995 by the government to fight the RUF, alongside the Sierra Leonean army (Harris, 2012). However, between the start of the civil conflict and the government's response, it was local resistance by the *Kamajors* in places like the Kailahun and Kono districts that fought the RUF and the military forces too (Harris, 2012; Mustapha, 2006). The *Kamajors* started as a grassroots militia with the mission of protecting families and villages, but as the organization grew larger, there were some problems with corruption and impeding the government forces (Harris, 2012). Harris (2012) says the army has a long history of being ineffective, mainly because the state did not scale up and equip it. In the 1970s and 1980s, the army reflected, in terms of ethnic and regional demographics, Temne and Limba northerners. Thus, it became a northern-based enclave to promote loyalty to the APC. Additionally, elements of the army and the RUF collaborated to loot towns and villages, with the head of state admitting that at least 20% of the army was disloyal (Harris, 2013). Thus, the average Sierra Leonean may have seen the army and the RUF equally as threatening (Harris, 2012).

There was a break in the fighting in 1996, after a coup led by Brigadier General Julius Maada Bio. Although this was a military coup, General Bio only stayed in power through the national elections in 1996 and stepped down afterward (Harris, 2012).³⁰ There is a debate about how and why Sierra Leone fell into civil war, as Bellows and Miguel (2009) and Harris (2012) do not believe ethnic tension was the source, even though it played a role in creating factions. However, the RUF did use diamonds and acquired land to fund their rebellion, which leads one to ask whether this was a greed-based or a grievance-based cause of conflict. In other words, there is a debate over whether the rebels were greedy for power and money, or whether they had grievances due to the lack of development and social mobility in life.³¹

1.4.2 Post-Conflict State-Building

³⁰ Bio was recently elected in the 2018 elections and is currently serving his first presidential term.

³¹ Harris (2012; 2013) explores the debate on the conflict and the role of blood diamonds in Sierra Leone. He does not believe these were the cause of the war but played an important role in financing efforts.

Peace and stability after the war have been major concerns for Sierra Leone in particular, and the Mano River region in general.³² Mustapha (2010) argues that Sierra Leone has been in a state of negative peace since the Lomé peace accord. He describes this as, “a situation characterized by the absence of direct violence (Ramsbotham, Woodhouse, and Miall 2005)—having failed thus far to put in place the conditions for sustainable, positive peace,” (Mustapha, 2010, p. 145). However, the problems in Sierra Leone reflect global inequities that are a result of global capitalism. Mustapha (2010) says that neoliberal policies have not only created global inequity, but they also recreate inequality at the local level. For example, there was a proliferation of jobs brought in by NGOs at the end of the war, but these required an educated and technically savvy workforce. Consequently, many young people are finding themselves unemployable: a similar situation before the war (Mustapha, 2010). Economic and infrastructure resources are highly centralized to urban areas, which also mimics the global political economy in terms of underdevelopment in the rural periphery.

Recreating these inequities at the local level could bring conflict again. For instance, Richards (2005) argues that the international community may not fully understand the nuances of why there was a rebellion in the first place. He says that there were grievances in the rural communities that stemmed from archaic customary laws and lack of education and occupational opportunities. Therefore, donors and development practitioners should prioritize agrarian and land tenure reforms to encourage young people into farming. However, liberalizing trade policies meant that import markets were flooded with cheap rice from Asia (a staple crop food), which made it difficult for local farmers to compete (Hanlon, 2005). Additionally, training provided to ex-combatants to become tailors, farmers, and other craftsmen were not enough for them to viably continue the trade and there was not enough demand in the local market for their services (Hanlon, 2005).

Since independence, Sierra Leone had a highly centralized system with a strong executive office; Siaka Stevens abolished all forms of local government in 1972. After the war, President Ahmad Tejan Kabbah’s administration started decentralization and held local elections (Jackson, 2006). However, there is a debate about whether the decentralization

³² Sierra Leone, Liberia, Côte d’Ivoire, and Guinea are part of the Mano River Union and sometimes these countries are collectively referred to as the Mano River countries or the Mano River region. It started in 1973 between Liberia and Sierra Leone and expanded after the civil wars (Mano River Union, 1973).

process is democratizing the state or reinstating ineffective local institutions. Conteh (2017) says that, despite being nearly two decades after the peace accord, the healthcare system remains centralized and vulnerable to corruption. This would give us a better perspective if we understood the context of decentralization and governance reforms.

Hanlon (2005) argues that the internationally-led development policies may be reinstating the same corrupt and ineffective institutions and macroeconomic policies that brought Sierra Leone to war in the first place. Specifically, these were the rushed elections at the national and local levels, including for paramount chiefs and IMF austerity measures targeting wage caps. The latter was flagged by the World Bank as a hindrance to recruiting and motivating the civil sector. Corruption at the state, parastatal, and private sectors were not addressed; the reintegration of ex-combatants and job creation were not priorities for the government or the IMF since wages were cut (Hanlon, 2005). However, unlike Liberia, the rebels of the RUF were not part of the transition, which may have had implications for reintegration (Harris, 2012).

The 2002 elections, which reinstated Kabbah in office – the donor community’s ‘favorite’,³³ were rushed before peace could be consolidated (Hanlon, 2005). The donor-led ‘race to the polls’ before establishing peace was also seen in the 1996 elections and subsequent return to arms (Hanlon, 2005; Harris, 2012; Zack-Williams, 1999). Hanlon (2005) says President Kabbah led a corrupt and partisan administration and his reinstatement of paramount chiefs went against advice to decentralize and democratize.³⁴ Hanlon (2005), Jackson (2005), and Richards (2005) say that paramount chiefs are an important cause of the war, by having alienated youth and women, and are authoritarian and corrupt.³⁵ Although Sawyer (2004; 2005b) argue that traditional leaders can help mediate conflict and resolve disputes. These local institutions are discussed further in chapter two.

However, Jackson (2006) says that the government wanted to build on its election victory and hold local elections early to keep the momentum. There was a nationwide

³³ Hanlon (2005) defines Kabbah as a puppet of the international donors, he received endorsements or resources to help with campaigns. Kabbah was elected in 1996 and removed via a coup but reinstated in 1998 with international support.

³⁴ In 2017, President Koroma increased the number of chiefdoms from 149 to 190 to deepen decentralization efforts with the support of the World Bank (All Africa, 2017; AYV Media Empire, 2017; Cocorioko, 2017; Concord Times, 2017; Kamara, S., 2017). See Cambayma (2017) for a dissenting view on this.

³⁵ There is a debate on how the chieftaincy institution was the main source of civil conflict as they are mainly led by older men, and thus, whether including this institution in post-conflict recovery will trigger another war. However, as mentioned earlier, traditional institutions for women were not considered in this debate. This is discussed in Chapter two, on page 71. See Fanthorpe (2001; 2006), Jackson (2005), Peters and Richards (1998) and Sawyer (2008).

consultation financed by the United Nations Development Programme (UNDP), however, the results of these consults did not lead to radical change. No district voted to remove the chiefdom institution, and some wanted more representation. A local electoral government was created with strong supervisory powers from Freetown. Jackson (2006) predicted slow devolution of powers, which as mentioned in Conteh (2017), is still slowly happening. Paramount chiefs have a central role in local government as administrators, and effectively control the entire bureaucracy for the district councils. However, the councils have the authority to set local tax rates and decide how tax funds will be spent, including whether to distribute funds to the chiefdoms (Jackson, 2006; Sawyer, 2008).

1.4.2.1 Non-State Actors

According to the 2014-2015 Afrobarometer survey, 65.5 % of respondents trust traditional leaders a lot/somewhat, while 51.8% gave the same answer when asked about the President. In terms of elected local councils that were created after the war only 31.5% had this level of trust (Afrobarometer, 2019). In the 2011-2013 survey, trust for the President was higher at 69.9% (a lot/somewhat) and for elected local officials at 44.1% (Afrobarometer, 2019). However, this question was not asked for traditional leaders in this survey. So, it seems that from 2013 to 2015, trust declined in state institutions. In addition, trust is higher for non-state institutions, demonstrating that at least since the end of the war, the chiefdom institutions have popular legitimacy.

1.4.3 Rebuilding the Healthcare System

Sierra Leone had an HRH shortage and 70% of its health facilities were not functioning by the end of the conflict (World Bank, 2003). The economic and security uncertainties led to a migration of healthcare professionals from Sierra Leone to other countries recruiting them. Over half of doctors born in Sierra Leone are now working in OECD countries, such as the United States or the United Kingdom (Sharples, 2015). According to Bertone and Witter (2015), in 2011 there were .0071 doctors and .0631 nurses per 10,000 people in the public sector. However, the 2014 Ebola epidemic killed many health workers, estimated at 21% of its HRH (Government of Sierra Leone, 2015; Raven, Wurie, and Witter, 2018).

Between 2003 and 2010, the Ministry of Health and Sanitation (MOHS) allocated less than \$4 USD per person per year for healthcare resulting in a collapse of these services and consequently, the highest child mortality and MMI rates (Keith and Cadge, 2010). Although the national policy was to provide health for mothers and children for free, this was not implemented until 2010, with support from the UK Department for International Development (DFID). Following this investment in health and the abolition of user fees for mothers and young children, Sierra Leone began reducing its child mortality rates (Keith and Cadge, 2010).

This program is referred to as the Free Health Care Initiative (FHI). However, the policy had the unintended consequence of threatening the livelihoods of traditional birth attendants (Dodgeon, 2010). Attendants used to receive a portion of user fees for referring pregnant women to a health center, but after the FHI, some centers found it difficult to persuade them to continue the referrals. Bertone and Witter (2015) say that the FHI had a lack of resources, training, and ineffective management that led to a mistrust of the healthcare system. Health workers reported not being paid on time (or at all) nor were provided with the necessary resources such as gloves, bandages, or fuel for generators. Some reported charging fees for treatment and supplies that the government should have been providing. This stagnated the state's attempt to prevent the poor from choosing between health care or financial distress (Bertone and Witter, 2015; Sharples, 2015). MOHS also set up a Facility Improvement Team to assess the readiness of health centers to implement the FHI. According to Abdullah and Kamara (2017), by July 2013 only a few centers met the minimum required standards (e.g. piped water, hospital beds, drugs, staffing...etc.). By July 2014 at the height of the Ebola epidemic, no facilities in the country passed the standards.

The FHI is administered through the MOHS and is executed by its district-level offices. Yet, there have been many logistical challenges. For instance, there is a shortage of trained HRHs and many facilities are under-equipped to handle the services covered under the FHI (International Monetary Fund, 2011b). Especially at the launch of the program, many facilities were unprepared to handle the sudden influx of new patients (M'Cormack-Hale and M'Cormack, 2016). MOHS was supposed to provide monitoring of district health facilities and teams. However, during Bertone and Witter (2015)'s fieldwork, they saw that state institutions set regulations and practices across the country, but at the district level,

informal practices emerge. Quarterly monitoring and evaluations are inconsistent if they do happen at all. Also, local councils and the district health management teams are not involved in recruiting staff or payment, as that comes from Freetown (MOHS).

The problems with the decentralization of recruitment, resources, and payroll to the district level may be related to the funding sources of the country's healthcare system and local political issues (Conteh, 2017). According to the 2011 PRS, the government acknowledged that its spending needed to increase to make the healthcare system sustainable and create a mechanism to pool donor funds. It also says that 95% of national response is donor-funded and that there are many civil service organizations and NGOs involved in the response, and this is a problem to keep track, coordinate, and monitor. Monitoring and evaluations are grossly underfunded and under-resourced to implement all poverty-reduction initiatives mentioned throughout the report (International Monetary Fund, 2011b).

However, Fanthorpe, Laval, and Sesay (2011) report that quantitative and qualitative indicators show a material impact of decentralization. Between 2005 and 2007, local councils that managed service deliveries showed improvements in primary health care. The qualitative data showed that other services improved such as more schools, sanitation, more roads, and the roll-out of the FHI.

The health system also relies on volunteers through health management committees throughout the country. They have different names, such as 'development committee' or 'village committee' and are funded through different NGOs, charities, funder and donor agencies (McMahon et al., 2017). Committees have different focuses and structures, but some are there to support health promotion and integrate community voices. In focus group discussions with committee volunteers in the Bo and Kenema districts conducted by McMahon et al. (2017), informants discuss close relationships with local health workers and the community, which included counting new inventory that arrived for the sake of transparency. Also, some informants discussed passing bylaws via the paramount chiefs to encourage healthy behaviors, such as leveraging a fine on lactating mothers who miss a postnatal appointment.

The FHI has made positive contributions and it is very popular among citizens (Witter et al., 2016). It is reliant on external funding, which is feasible because the initiative was designed to achieve MDGs 4 and 5. There are many NGOs on the ground providing health

services today in Sierra Leone, but these are often service-specific (like childhood immunizations or HIV/AIDS testing) and thus, do not serve the broader public. Not only may these NGOs not represent the greatest health need of a village, but they sometimes will siphon local health workers to work for them, leaving state-sponsored clinics understaffed or closed (Bertone and Witter, 2015). Moreover, senior health workers are placed in administrative capacities where they are no longer using their much needed clinical skills (Abdullah and Kamara, 2017).

Herrick and Brooks (2018) also discuss the challenges of donor-recipient³⁶ relations in the health sector in Sierra Leone. While the term ‘partnership’ implies an equitable relationship on paper, the reality is different. Western volunteers learn that although ‘partnership’ is used, local health workers expect donors to bring everything; even though MOHS is supposed to bring some equipment. However, since the hospital has a sponsoring partner, such as Kings College from the United Kingdom, MOHS resources are bypassed to another facility, ideally one without an external partner. This is the fungibility of aid (Farang et al., 2009),³⁷ where sometimes aid replaces as opposed to supporting current systems. Fungibility could imply that the demand for health resources is not being met. Bertone and Witter (2015) and Herrick and Brooks (2018) present these challenges of implementing the FHI and developing the healthcare system horizontally.

According to Sharples (2015), there would be enough financial resources to provide UHC if the government had stronger management of taxation on its extractives industry. Governments of low-income countries, like Sierra Leone, could provide UHC at a minimum of \$86 USD per person per year. The author estimates that taxation could raise between \$94 to \$199 million USD per year, which is short of the minimum \$524 million USD needed in Sierra Leone; but, this could help supplement UHC efforts, along with aid (Sharples, 2015). However, the author says that \$1.1 billion USD was pledged to combat the EVD outbreak in the country. This shows the disparity in donors’ preferences³⁸ to channel aid, as it seems there are financial resources to strengthen the healthcare system, but rather, they react to

³⁶ This article broadly uses the term ‘donor.’

³⁷ For instance, there is a concern of fungibility and its impacts on sectors in low-income countries’. Fungibility is, “when government offsets donor spending for a particular purpose by reducing its expenditures on the same purpose and therefore aid substitutes rather than supplements local spending,” (Farang et al., 2009, p. 1045). The health and agriculture sectors tend to be the most affected by the substitution of aid funds resulting in reduced services. If a middle-income country receives aid and decreases its spending on a sector, it does not impact it as negatively as a low-income country. This is because wealthier countries tend to spend more on their sectors.

³⁸ This report uses the terms, ‘donors’ and ‘donor aid.’

an acute emergency while overlooking the broader picture. This highlights a difference in the priorities made on the supply-side (providers of aid) and demand-side (recipients of aid) in the aid market.

According to the last PRS papers before the EVD outbreak, the macroeconomic overview showed a growing trade deficit because the country's exports declined in the global markets (International Monetary Fund, 2011b). Although it had improved since 2012, the economy is still very weak to compete in the global market (International Monetary Fund, 2012). Additionally, its primary exports are in the mining and agriculture sectors, so it remains exposed to the volatility of international commodity markets (International Monetary Fund, 2011b). Therefore, advocating for UHC to be heavily reliant on a narrow extractives industry may make service delivery more challenging than it already is, especially if commodity prices fall.

1.4.4 'Poor Governance' in Sierra Leone

According to its 2005 PRS, poverty was a pervasive factor throughout society, standing at 70% (International Monetary Fund, 2005), the government aligned its policies of addressing underdevelopment by adopting the framework of the MDGs for "bold and appropriate sectoral policies, measures and institutional reforms that achieve economic growth, increase food security, increase job opportunities and provide better basic social services, as well as effective social safety nets for the poor and vulnerable." (International Monetary Fund, 2005, p. 75). However, this does not mean these were implemented during this time. Jackson (2011, p. 208) says that Sierra Leone has been considered a success story, in terms of the state being "reconstructed by the international community" however, that does not necessarily mean a strengthening of local governance.

Sierra Leone has been called one of the worst places in the world for a child to be born (Keith and Shackleton, 2006; Mason, 2016; VSO International, 2019) or one of the worst countries to live in (Abdullah and Kamara, 2017). This is regarding it consistently having one of the highest MMI rates since the 1990s. It also ranked very high for child deaths (under age five mortality); according to Keith and Shackleton (2006), the death rates for women and children were largely attributed to user fees. Malaria, which can be fatal in young children, cost £4.24 GBP or 18,000 Leones to treat. However, the average Sierra Leonean would have to work for 14 days to earn this, the equivalent of a British citizen

paying £700 GBP for Malaria treatment (Keith and Shackleton, 2006). Before the creation of FHI, out of pocket expenditures on health services were over 80%, which according to Witter et al. (2016) was worse than most, if not all, low-income countries.³⁹ Jain, Brown, and Johnson (2015) say that one in ten women risk dying during pregnancy or childbirth and almost one in every three children, under the age of five, dies. Creating the FHI was a positive step to improve health governance (Dodgeon, 2010; Witter et al., 2016). Prior to 2010, Keith and Cadge (2010) and Keith and Shackleton (2006) believe that Sierra Leone relied on vertical interventions in its healthcare system and not horizontal strengthening.

1.5 Reflections on Post-Conflict Recovery

Guttal (2005, p. 73-74) says that post-conflict recovery is about setting up a market-based capitalist economic system with a political regime to support and defend the free-market. Success or failure of these development efforts are not measured by broad social, economic, political, or security trends of the domestic population, but rather if countries are complying with the externally-determined standards of a market economy, 'good governance', and liberal democracy. Therefore, these policies keep states in a persistent condition of failure, rather than recovery.

The MDGs were part of the global governance indicators that low-income countries used to define and assess overall poverty reduction and development strategies; this was created by the UN and the PRS funded the implementation of the MDGs (International Monetary Fund, 2011a). The PRS tends to have a lack of clarity around financial resources available for health, including how PRS-related debt relief will partly or fully replace government funds for health. The PRS was created for aid effectiveness and good governance, but in many cases may lead to aid fungibility (Farang et al., 2009).

Vertical interventions, often led by Western-derived NGOs to do selective health services, such as HIV/AIDS or Malaria treatments were preferred. This is in the context of liberal economic reforms, as these were cost-effective interventions rather than system-wide strengthening. Although Liberia had a pooled funding mechanism and was able to

³⁹ Out of pocket expenses vary widely between countries, but catastrophic spending on health (defined as greater than 40% of income after subsistence needs are met) are higher in low-income countries. This could be the causal link between ill health and impoverishment, if one has to choose between healthcare expenses and other needs (Xu et al. 2003).

prioritize its health services for a few years after the war, based on the indicators below, it is unclear how this impacted the health system broadly or in the long-term.

1.5.1 Comparing Health Indicators

Table 1.1 is health workers per 10,000 persons from 2005 to 2010 (World Health Organization, 2012b). This demonstrates a significant shortage of HRH. Just as a comparison, the United Kingdom, which has UHC, had 27.4 physicians and 101.3 nurses/midwives per 10,000 during this period (World Health Organization, 2012b). If a country has at least 2.5 health workers (all professions) per 1000 persons (25 per 10,000); achieving 80% coverage for immunizations or skilled delivery of infants is more likely (Chen et al., 2004).

| Table 1.1 HRH Density per 10,000 persons | | |
|---|----------------|---------------------|
| Health Workers | Liberia | Sierra Leone |
| Physicians | 0.1 | 0.2 |
| Nurses/Midwives | 2.7 | 1.7 |
| Dentists | <0.05 | <0.05 |
| Pharmaceutical workers | 0.8 | 0.3 |
| Public Health workers | 0.1 | 0.2 |
| Community Health workers | N/A | 0.2 |
| Psychiatrists | <0.05 | <0.05 |

Table 1.2 shows a decrease in infant mortality and childhood mortality rates over two decades. This is to be expected as it starts from the conflict period. The data are from the World Health Organization (2012b).

| Table 1.2 Infant and Childhood Mortality Rates per 1000 live births | | | |
|--|-------------------------------|------------------------------|---------------------|
| Year | Infant Mortality Rates | Under Age 5 Mortality | Countries |
| 1990 | 151 | 227 | Liberia |
| 1990 | 162 | 276 | Sierra Leone |
| 2000 | 115 | 169 | Liberia |
| 2000 | 142 | 233 | Sierra Leone |
| 2010 | 74 | 103 | Liberia |

| | | | |
|-------------|-----|-----|---------------------|
| 2010 | 114 | 174 | Sierra Leone |
|-------------|-----|-----|---------------------|

Table 1.3 is from the Global Health Observatory on the WHO’s website. This recent data for infant and childhood mortality rates per 1000 live births (World Health Organization, 2016b; World Health Organization, 2016c).

| Table 1.3 Global Health Observatory on Infant and Childhood Mortality | | | |
|--|-------------------------------|------------------------------|---------------------|
| Year | Infant Mortality Rates | Under Age 5 Mortality | Countries |
| 2012 | 65.4 | 89.7 | Liberia |
| 2012 | 99.8 | 145.6 | Sierra Leone |
| 2015 | 59.3 | 80.1 | Liberia |
| 2015 | 88.1 | 122.2 | Sierra Leone |

After 2010, Sierra Leone saw improvements in some health indicators such as childhood, infant, and maternal mortality. This partly due to the implementation of the FHI (Witter et al., 2016). Whereas, in Liberia, funding and support began to decrease after this period from NGOs and donors (Newbrander, Waldman, and Shepherd-Banigan, 2011). Nonetheless, indicators on childhood and infant mortality rates show both countries had improved infant and child health since the conflict period. However, it is difficult to discern which country improved its health system based on these quantitative indicators alone. For example, the tables below examine access to health services and health inequities for nonMDG-related indicators.

Table 1.4 shows the percentage of DTP3 Immunizations among one-year olds, this vaccine is not part of the MDGs (World Health Organization, 2012b). Sierra Leone had higher coverage of this vaccine to children from poorer families and rural areas.

| CATEGORIES | Place of Residence | | Wealth Quintile | | Education level of Mother | |
|---------------------|---------------------------|--------------|------------------------|----------------|----------------------------------|----------------------------|
| | Urban | Rural | Lowest | Highest | None | Secondary or Higher |
| Liberia | 70% | 41% | 30% | 72% | 47% | 70% |
| Sierra Leone | 70% | 58% | 56% | 73% | 57% | 76% |

Table 1.5 shows the percentage of children under age five who are stunted, this is not assessed as part of the MDGs (World Health Organization, 2012b). Both countries are comparable in this indicator, although Sierra Leone has slightly lower rates.

| CATEGORIES | Place of Residence | | Wealth Quintile | | Education level of Mother | |
|---------------------|--------------------|-------|-----------------|---------|---------------------------|---------------------|
| | Urban | Rural | Lowest | Highest | None | Secondary or Higher |
| Liberia | 29% | 41% | 43% | 25% | 40% | 28% |
| Sierra Leone | 28% | 38% | 35% | 22% | 38% | 23% |

1.5.2 Liberia as a Model of Post-Conflict Development

Liberia made progress in life expectancy indicators from 1990 to 2012 (Keith and Cadge, 2010; Nkwanga, 2015). In addition, it improved in other indicators such as health financing and some of the 2015 MDGs. However, that is not to say that Sierra Leone had not improved. The interpretation of these indicators needs more nuance, as we see that both countries had different starting points. Petit et al. (2013) say that initial good results should be expected as the BPHS are executed and monitored via quantitative indicators, but system-wide challenges could be hidden if we only rely on these indicators to assess governance.

Relying on a few indicators can also distort service delivery (prioritizing a massive amount of funding on a singular issue) and create an illusion of progress, regression, or stagnation. This may explain why Liberia initially had good results (Petit et al., 2013). Moreover, it is also used to label countries as having poor or weak governance, such as Sierra Leone in maternal, infant, and child mortality indicators. This does not only happen in health governance but development policies broadly, such as claiming Sierra Leone as one of the world’s fastest-growing economies (Fofana, 2014a; International Monetary Fund, 2012);⁴⁰ while numbers do not lie, the truth can be hidden.

For example, there is still more aid available for HIV/AIDS or Malaria than there is for mental health; which according to Liberia’s former minister for MHSW, is desperately needed in a post-conflict state that only has one certified psychotherapist (Kruk et al., 2010). Liberia achieved many indicators on the global health agenda and was seen as a post-

⁴⁰ After the war, activity in the mining sector resumed in Sierra Leone. This led to a 20% GDP growth from 2012-2013. However, more than half of the country’s six million citizens live on less than \$1.25 USD per day (Fofana, 2014a).

conflict success story, but the health system struggled to identify and contain the spread of EVD in 2014 (Pailey, 2017).

1.5.3 Building the State Institutions

Post-conflict development and health interventions have different stakeholders, but there is some overlap as much of the financing comes from IFIs, and thus, macro-political and economic conditionalities are imposed for recipient countries. These have also resulted in increased inequalities and social polarization in some cases, as only a few will benefit from market opportunities (Guttal, 2005). Mulbah (2018) says that state-building in Liberia has followed a modern and Weberian understanding of what the state is, and hence, rendering local and traditional institutions invisible. These institutions have been portrayed as developmental delays, rather than as an artifact of the state. The international community's development practices comprise of a standard set of reforms and projects delivered to low-income countries:

State-building can also be categorised into tasks of political development, building administration, justice, PFM and security (Call 2008), which correlate with the apparent normative objectives of state-building: security, democracy, economic development and the rule of law. The four thematic areas of the state translate into empirical state-building practices, namely SSR [Security System Reform] and human security (i.e. security); elections and democracy support (i.e. legitimacy); IFI policies and PRS (i.e. economic policy-making and public finances); and judicial reform, SSR and the training of the police force (i.e. rule of law) (Mulbah, 2018, p. 71).

In Sierra Leone and Liberia, peacebuilding, elections, peacekeeping missions, and even international criminal court trials are practices meant to bring security and legitimacy to the state. However, both countries have dual systems of justice, governing, and security through indigenous or traditional institutions (Conteh, 2013; Harris, 2013; Tokpa and Yengbeh Jr., 2012; UNDEF, 2014). These reforms are meant to introduce and build new institutions for capitalist-led economic growth, but not for broader socioeconomic development (Gray, 2016). These indicators measure how state institutions are governing but not non-state institutions like the chiefdoms. Therefore, it is important to understand how citizens see themselves in relation to the state and traditional institutions.

The tables below are generated from the 2014/2015 Afrobarometer surveys, from the organization's website, using the data comparison tool (Afrobarometer, 2019).

Table 1.6: How satisfied are respondents with the way democracy works in ____ country?

| Category | Total | Liberia | Sierra Leone |
|----------------------------|---------------------|---------------------|---------------------|
| Country is not a democracy | 1.1% | 1.0% | 1.1% |
| Not at all satisfied | 19.8% | 23.2% | 16.3% |
| Not very satisfied | 23.4% | 26.8% | 20.0% |
| Fairly satisfied | 22.2% | 28.8% | 15.6% |
| Very satisfied | 14.0% | 14.5% | 13.5% |
| Don't know | 19.6% | 5.7% | 33.5% |
| (N) | 2,386 (100%) | 1,195 (100%) | 1,191 (100%) |

Table 1.7: How much do you trust the President?

| Category | Total | Liberia | Sierra Leone |
|---------------|---------------------|---------------------|---------------------|
| Not at all | 24.7% | 31.5% | 17.8% |
| Just a little | 31.6% | 37.5% | 25.7% |
| Somewhat | 16.8% | 16.0% | 17.7% |
| A lot | 24.0% | 14.1% | 34.1% |
| Don't know | 2.8% | 0.9% | 4.7% |
| (N) | 2,390 (100%) | 1,199 (100%) | 1,191 (100%) |

Table 1.8: How much do you trust the local government councils?

| Category | Total | Liberia | Sierra Leone |
|---------------|---------------------|---------------------|---------------------|
| Not at all | 28.3% | 23.8% | 32.9% |
| Just a little | 36.4% | 43.6% | 29.1% |
| Somewhat | 20.6% | 21.9% | 19.3% |
| A lot | 10.5% | 8.8% | 12.2% |
| Don't know | 4.2% | 1.9% | 6.6% |
| (N) | 2,390 (100%) | 1,199 (100%) | 1,191 (100%) |

Table 1.9: How much do you trust the army?

| Category | Total | Liberia | Sierra Leone |
|---------------|-------|---------|--------------|
| Not at all | 18.6% | 22.8% | 14.4% |
| Just a little | 27.9% | 32.4% | 23.4% |
| Somewhat | 25.0% | 27.4% | 22.5% |

| | | | |
|-------------------|---------------------|---------------------|---------------------|
| A lot | 25.3% | 15.7% | 34.9% |
| Don't know | 3.3% | 1.7% | 4.8% |
| (N) | 2,389 (100%) | 1,198 (100%) | 1,191 (100%) |

Table 1.10: How much do you trust the courts of law?

| Category | Total | Liberia | Sierra Leone |
|----------------------|---------------------|---------------------|---------------------|
| Not at all | 27.5% | 25.4% | 29.6% |
| Just a little | 34.4% | 41.4% | 27.4% |
| Somewhat | 22.1% | 24.1% | 20.1% |
| A lot | 9.8% | 7.5% | 12.2% |
| Don't know | 6.2% | 1.7% | 10.7% |
| (N) | 2,390 (100%) | 1,199 (100%) | 1,191 (100%) |

Table 1.11: How much do you trust parliament or national assembly?

| Category | Total | Liberia | Sierra Leone |
|----------------------|---------------------|---------------------|---------------------|
| Not at all | 31.4% | 30.0% | 32.9% |
| Just a little | 33.7% | 38.3% | 29.2% |
| Somewhat | 21.4% | 22.3% | 20.5% |
| A lot | 9.7% | 8.5% | 10.9% |
| Don't know | 3.7% | 0.9% | 6.6% |
| (N) | 2,390 (100%) | 1,199 (100%) | 1,191 (100%) |

Table 1.12: Do you approve or disapprove of the way that the President performed his/her job over the past twelve months, or haven't you heard enough about them to say?

| Category | Total | Liberia | Sierra Leone |
|--|---------------------|---------------------|---------------------|
| Strongly disapprove | 26.7% | 32.7% | 20.6% |
| Disapprove | 28.4% | 33.3% | 23.4% |
| Approve | 28.2% | 23.9% | 32.6% |
| Strongly approve | 13.6% | 8.7% | 18.5% |
| Don't know/Haven't heard enough | 3.1% | 1.3% | 4.9% |
| (N) | 2,388 (100%) | 1,199 (100%) | 1,189 (100%) |

Table 1.13: Do you approve or disapprove of the way that the member of national legislature performed his/her job over the past twelve months, or haven't you heard enough to say?

| Category | Total | Liberia | Sierra Leone |
|---------------------------------|--------------|--------------|--------------|
| Strongly disapprove | 35.1% | 34.3% | 36.0% |
| Disapprove | 34.7% | 34.6% | 34.7% |
| Approve | 20.1% | 24.1% | 16.0% |
| Strongly approve | 6.2% | 5.9% | 6.5% |
| Don't know/Haven't heard enough | 3.9% | 1.0% | 6.7% |
| (N) | 2,388 (100%) | 1,199 (100%) | 1,189 (100%) |

Table 1.14: Do you approve or disapprove of the way that the member of the local council performed his/her job over the past twelve months, or haven't you heard enough to say?

| Category | Total | Liberia | Sierra Leone |
|---------------|--------------|--------------|--------------|
| Not at all | 28.3% | 23.8% | 32.9% |
| Just a little | 36.4% | 43.6% | 29.1% |
| Somewhat | 20.6% | 21.9% | 19.3% |
| A lot | 10.5% | 8.8% | 12.2% |
| Don't know | 4.2% | 1.9% | 6.6% |
| (N) | 2,390 (100%) | 1,199 (100%) | 1,191 (100%) |

Table 1.15 Do you think that leaders of political parties in this country are more concerned with serving the interests of the people, or more concerned with advancing their own political ambitions, or haven't you heard enough to say?

| Category | Total | Liberia | Sierra Leone |
|--|--------------|--------------|--------------|
| More to serve their own political ambitions - strongly agree | 47.6% | 35.9% | 59.4% |
| More to serve their own political ambitions - agree | 27.4% | 32.0% | 22.8% |
| Neither agree nor disagree | 5.7% | 7.0% | 4.4% |
| More to serve the people - agree | 8.1% | 14.1% | 2.0% |
| More to serve the people - strongly agree | 6.9% | 8.6% | 5.3% |
| Don't know | 4.3% | 2.5% | 6.1% |
| (N) | 2,382 (100%) | 1,191 (100%) | 1,191 (100%) |

Table 1.16 How many of the following people do you think are involved in corruption, or haven't you heard enough about them to say? The President and officials in his office.

| Category | Total | Liberia | Sierra Leone |
|--------------|-------|---------|--------------|
| All of them | 23.9% | 32.7% | 15.1% |
| Most of them | 31.8% | 30.5% | 33.1% |
| Some of them | 33.4% | 31.8% | 35.1% |

| | | | |
|-------------------|---------------------|---------------------|---------------------|
| None | 3.7% | 3.4% | 4.1% |
| Don't know | 7.1% | 1.6% | 12.6% |
| (N) | 2,390 (100%) | 1,199 (100%) | 1,191 (100%) |

Tables 1.6 to 1.16 demonstrate lukewarm trust towards state institutions, except for the presidency in Sierra Leone during this year; there are high disapproval ratings on official performance for the past 12 months of each level of government. Trust is an important component in building a nation on common grounds. Additionally, it is needed for leadership in a public health emergency (Morse et al., 2016). Development policies are limited in building trust between people and their governments. This is not to say that the relationship between the state and the people are hopeless, but rather, changes in service delivery and accountability are needed to build trust. And not all of these can be externally led. In Sierra Leone, the majority still trust and approve of the president, while nearly half believe that all or most officials in the office are corrupt (Tables 1.7 and 1.16). It could be the way the question is phrased, as trust and performance approvals are centered on the person, while the question of corruption is asked about the office. So, one may see cabinet members and associates as corrupt but not the president. Or, as we will discuss in the next chapter, respondents may view elected officials as self-serving and not accountable; this is an unintended consequence of democratic reforms. Chapter two, section 2.2.1.2, discusses the argument that elections will clear out corrupt candidates, but the reality is more complicated.

In terms of traditional leaders, Afrobarometer asked these following questions in the 2014/2015 surveys Tables 1.17 to 1.19 (Afrobarometer, 2019):

Table 1.17: How much do you trust traditional leaders?

| Category | Total | Liberia | Sierra Leone |
|----------------------|---------------------|---------------------|---------------------|
| Not at all | 13.0% | 15.0% | 11.1% |
| Just a little | 25.8% | 33.1% | 18.6% |
| Somewhat | 29.3% | 29.5% | 29.1% |
| A lot | 28.3% | 20.3% | 36.4% |
| Don't know | 3.5% | 2.2% | 4.8% |
| (N) | 2,387 (100%) | 1,196 (100%) | 1,191 (100%) |

Table 1.18: Do you approve or disapprove on how traditional leaders performed their jobs in the past 12 months?

| Category | Total | Liberia | Sierra Leone |
|---------------------------------|---------------------|---------------------|---------------------|
| Strongly disapprove | 14.9% | 17.5% | 12.2% |
| Disapprove | 21.0% | 25.1% | 16.8% |
| Approve | 41.3% | 40.0% | 42.6% |
| Strongly approve | 18.0% | 14.0% | 22.0% |
| Don't know/Haven't heard enough | 4.8% | 3.4% | 6.3% |
| (N) | 2,387 (100%) | 1,199 (100%) | 1,189 (100%) |

Table 1.19: Involvement in corruption?

| Category | Total | Liberia | Sierra Leone |
|--------------|---------------------|---------------------|---------------------|
| None | 11.0% | 8.6% | 13.4% |
| Some of them | 44.3% | 47.6% | 40.9% |
| Most of them | 25.4% | 25.6% | 25.2% |
| All of them | 12.6% | 15.3% | 10.0% |
| Don't know | 6.7% | 3.0% | 10.5% |
| (N) | 2,386 (100%) | 1,195 (100%) | 1,191 (100%) |

Tables 1.17 to 1.19 show relatively more positive attitudes towards traditional leaders than elected officials. 65.5% of Sierra Leonean respondents say they trust traditional leaders a lot/somewhat in table 1.17. This is higher than trust ratings for the President at 51.8% (Table 1.7) or local elected officials that were installed after the war (31.5% in table 1.8). 49.8% of Liberians trust traditional leaders in table 1.17, compared to the President at 30.1% in table 1.7 or 30.7% who trust local elected officials in table 1.8. In Sierra Leone, 35.2% of respondents believe that most or all traditional leaders are corrupt in table 1.19, compared to 48.2% when asked about the executive office in table 1.16. In Liberia, 40.9% believe that all or most traditional leaders are corrupt compared to 63.2% when asked about the executive office in tables 1.19 and 1.16 respectively. Thus, there needs to be an examination of why there are more positive perceptions of traditional institutions that are not democratically elected, and in some cases, people may prefer nonliberal forms of government (Fanthorpe, 2006).

Voors and Bulte (2014) say there is scant evidence-based research to support evolutionary or design-based theories of institutional quality.⁴¹ The design-based theories are the development models such as the good governance reforms. The authors say when there are internal pressures such as violence or shocks, this would create bottom-up changes to institutions: a change in local preferences and beliefs. They found no evidence that NGO or state-led interventions impact institutional quality. Also, changes due to internal pressure are not always positive, such as those exposed to violence have a worse view of the state (police, army...etc.). However, Bellows and Miguel (2009)'s research on collective action in Sierra Leone demonstrates that chiefdoms and households that experienced violence are more likely to be politically involved in post-conflict recovery, in terms of mobilization, engagement, and public goods contribution. For example, Sawyer (2008) observed paramount chiefs participating in national and local elections after the war.

Section 1.5 gives enough contextual information to understand the state of affairs in Liberia and Sierra Leone, including the challenges and successes in reforming the state for development. Non-state institutions are not discussed in depth in the broader good governance framework, however, this will be conceptualized in the next chapter. The beginning of the chapter discussed priorities and challenges on the supply-side of the aid market. Therefore, this final section gives a brief introduction to the EVD outbreak and the macro-level discussion regarding the response from the international community and challenges in the supply-side of the aid market.

1.6 Introduction to the 2014 Ebola Epidemic

Ebola is a filovirus, which is a taxon of viruses that consist of a single strand ribonucleic acid; and is one of the oldest pathogens known, dating back to tens of millions of years ago (Taylor, Leach, and Bruenn, 2010). It is fragile but one of the more lethal pathogens known to man. Before 2014, this was a neglected tropical disease that broke out in obscure places (Preston, 2012). AIDS, which “kills much more slowly than Ebola” (Preston, 2012, p. 66), is one of the largest and active pandemics in our history. However, Ebola, for several months, paralyzed an entire region and spread fear among the global community.

⁴¹Voors and Bulte (2014) define institutional quality in these four criteria: rights security, appreciation of local political institutions, rule of law, and social capital. Social capital is defined as trust and cooperation. Some of these concepts of institutions and institutional quality will be discussed in the next chapter on the theoretical framework for this thesis.

On March 23, 2014, the WHO issued its first response regarding the prevalence of EVD in West Africa (Centers for Disease Control and Prevention, 2019). It said that the initial case was a small boy who had encountered a fruit bat, then died in December 2013 in the Guéckédou prefecture in southern Guinea. This province borders northwestern Liberia and eastern Sierra Leone. There were suspicions of a hemorrhagic fever in the southern forested region of the country (Toukara, 2014). Finally, the Guinean health officials announced on March 22nd that EVD was present in the country and had already killed 34 people since February 9th (Africaguinee, 2014). Liberia had started investigating suspicious cases since the beginning of 2014 and Sierra Leone started around April. Liberia confirmed its first EVD case on March 30th in the northern county of Lofa and by May 25th, Sierra Leone's first confirmed case was announced in the eastern district of Kenema⁴² (Davies and Rushton, 2016; DePinto, 2016).

For this thesis, I divide the Ebola epidemic into two periods: phase one and phase two. The first phase is from December 2013 to September 2014, a month after the WHO declared the EVD outbreak a Public Health Emergency of International Concern (PHEIC). The second phase is from October 2014 until the WHO declared the entire epidemic finished in 2016. The second phase saw a scale up of aid and donor resources, where international agencies and countries promised resources and several intervened. Although it is called a 'scale up' it is not to depict billions of dollars flooding in immediately. Bullard (2018)'s research shows that many donors and NGOs took longer to arrive, some coming as late as December 2014. Furthermore, although resources, such as field hospitals and ambulances were promised, not all were brought in or built (Nyenswah et al., 2016). And, as mentioned earlier, both countries already had aid resources providing services when the outbreak began and some continued to deliver services throughout the epidemic.

The epicenter of the EVD outbreak was in a heavily forested region of southern Guinea, eastern Sierra Leone, and northern Liberia. According to Bausch and Schwarz (2014), this area regularly has high mobility where humans encounter different kinds of animals and creatures. At the time, some experts believed this outbreak represented a few 'firsts' for EVD. For instance, the first time since the disease was discovered that it affected a densely populated urban area and it is also the first time EVD was reported in West Africa

⁴² The patient was from the eastern district of Kailahun but went for a blood test in the Kenema District, where the EVD diagnosis was confirmed.

(Gatherer, 2014). However, the urban city of Kikwit in the Democratic Republic of Congo experienced a serious EVD outbreak in 1995 (Epstein, 2014). Furthermore, there was an isolated case in Liberia where someone tested positive with Ebola antibodies, meaning she or he was previously infected (Knobloch, Albiez, and Schmitz, 1982). Afterward, there was an isolated case in Côte d'Ivoire, where an ethologist was infected while performing a necropsy on a chimpanzee (Formenty et al., 1999; Le Guenno et al., 1995).

1.6.1 The WHO's Response

There is a debate regarding the challenges on the supply-side of the response. According to McInnes (2016 p. 381), the WHO's initial response was "anemic", where the main actor advocating for resources and mobilization efforts to West Africa was MSF. They even testified at a UN Security Council (UNSC) hearing about the crisis and weak response.

The WHO was struggling to keep up with the demands of this outbreak, and outbreaks elsewhere, as its budget had been cut in the years before (Boseley, 2014; Gostin and Friedman, 2014; Kamradt-Scott, 2016). Additionally, other international organizations have been influential in health interventions for many years, especially since they had a greater capacity to respond. Thus, parallel agencies were created, such as the United Nations Mission for Ebola Emergency Response, resulting in a complex network of actors (Benton and Dionne, 2015; Kickbusch and Reddy, 2015). These first two arguments would be the outcome of liberalizing global health, as discussed in section 1.2.2.

A third argument suggests structural problems at the WHO made it slower to respond (Kamradt-Scott, 2016; Kickbusch and Reddy, 2015; Moon et al., 2015). The organization behaves as seven separate components instead of one and there is bureaucratic red-tape to enact PHEIC. The agency is headquartered in Geneva, Switzerland but the seven regional entities each have their staff, administration, resources, and separate funding. For example, the Pan-American Health Organization, which is in the United States and monitors health trends in North and South America, is older than the headquarters in Geneva (PAHO/WHO, 2018.). It also has more resources at its disposal than say, the AFRO regional office located in Brazzaville, Congo. News sources reveal that senior officials in the WHO had wanted to enact the PHEIC as early as June 2014 as they understood the circumstances in West Africa (Cheng and Satter, 2015). Perhaps, bureaucratic challenges hampered a response.

Another argument suggests the agent shirked its responsibilities. If the WHO secretariat is the agent and its members, the 193 nations, are the principals, then its response could be regarded as agency slack (Kamradt-Scott, 2015). This is when the agent develops divergent interests or concerns from the principals and acts on them. This is not the first time there was an agency slack during a public health intervention (Godlee, 1994; Graham, 2014; Kamradt-Scott, 2015). For example, Kamradt-Scott (2015, p.77) says that the success of the Smallpox eradication program in the 1960s and 1970s was partly due to the WHO's "hands-off and more decentralized" approach. It continued with this in other disease eradication programs (Tuberculosis, Polio, etc...). It shirked its responsibility as the international lead technical agency to instead rely on member states to invite them in.

Regarding the WHO's role in emergency outbreaks, this was former Director-General Chan's response to the New York Times in September 2014 (Fink, 2014). This could be regarded as an example of agency slack:

Q. You managed the SARS emergency in your former position as the director of health of Hong Kong, so you're obviously well acquainted with outbreaks. Can you lay out the chronology of the W.H.O.'s response to the current Ebola outbreak, once the W.H.O. was notified of it in March?

A. First and foremost, people need to understand W.H.O. W.H.O. is the U.N. specialized agency in health. And we are not the first responder. You know, the government has first priority to take care of their people and provide health care. W.H.O. is a technical agency.

Q. How do affected countries work with the W.H.O.?

A. They will invite W.H.O. to provide technical advice and also technical support. Now, what does that mean? For example, if they have a cholera outbreak, if they have you know an Ebola outbreak, they would ask us: "What are the good practices to control the outbreak? If the countries say, "Well, we may need an epidemiologist or we may need some laboratory support," then W.H.O. will call on our partners, which would include countries or include scientific organizations, like the C.D.C...So this is how we provide services. We are not like international N.G.O.'s, for example M.S.F. [Doctors without Borders], Red Cross, Red Crescent or local N.G.O.'s who are working on the ground to provide, you know, direct services. (Fink, 2014)

Kamradt-Scott (2015) says the agent (WHO secretariat) shirked during the 2014 EVD epidemic and failed to intervene properly. The different arguments presented above range from structural to political constraints. These factors and others such as knowledge sharing are discussed in an autopsy report by an independent panel (Moon et al., 2015). Kamradt-Scott (2015) says that the 2014 EVD outbreak may be the WHO's biggest failure since the response to HIV/AIDS in the 1980s. Both epidemics started in Africa, in poor fragile states that did not have the health infrastructure to identify, contain, and respond to disease outbreaks.

1.6.2 Lessons for GHG and the Outbreak

Thus, in comparing the response to HIV/AIDS, there are parallels and lessons learned on the challenges of GHG (Drain, 2015; Keneally, 2014; Rabkin and El-Sadr, 2015). For instance, the HIV/AIDS pandemic became securitized as a regional and global threat and it was elevated before the UNSC as a health security problem.⁴³ So was EVD, which led to the creation of a separate UN Mission (McInnes, 2016).

The response to the HIV/AIDS pandemic was also largely focused on preventing and correcting 'bad behaviors' (e.g. condom distribution for performance-based indicators) and promulgated the stereotype of hypersexualized Africans spreading STIs (Caldwell, Caldwell, and Quiggin, 1989). This discourse helped to depoliticize and distract from the socioeconomic and political determinants of health, by racializing and stigmatizing persons with HIV/AIDS (Johnston, 2015; Mustapha, 2006). During the EVD outbreak, the Western media also focused on 'bad behaviors' of local people continuing to bury loved ones, avoiding the health centers, or escaping from them (Moran, 2015). Behaviors or decisions that were not seen as rational to Western observers were classified as religious or superstitious (Gerlach, 2016; Grundy, 2014). However, these reactions may actually indicate a barrier in addressing demand-side challenges in the market and the donors' and humanitarians' limited capabilities to address cultural, religious, social, and logistical factors on the ground. The demand-side barriers will be explored in the next chapter.

The intervention also relied on mostly biomedical methods, such as the building of Ebola Treatment Units (ETUs),⁴⁴ developing mobile diagnostic units, and the use of experimental drugs and treatments, which did not address the social etiology of this outbreak. This was a similar response to HIV/AIDS before it evolved (Pisani, 2011). Like AIDS, EVD has no vaccine or cure. However, there was huge pressure to create pharma-medical resources. According to Gericke (2015), this raised serious ethical dilemmas as there was a rush to treat people with experimental drugs and vaccines. Although the experimental and limited drug, ZMapp, was mainly used on repatriated health workers from Western

⁴³ Security has been used to justify cooperation into public health matters. In fact, the bill that created PHEIC was based on the premise that there is a security risk if the WHO does not intervene. In addition, resources deployed such as the military, may not have experience conducting health interventions. See Aldis (2008), Bond (2008), Davies and Rushton (2016), De Waal (2010; 2014), and Kamradt-Scott (2015) for further reading on health security.

⁴⁴ Different countries and sources refer to these as Ebola Treatment Centers using ETCs as an abbreviation. However, ETU(s) is use throughout the thesis for consistency.

countries while also injecting a serum made from the blood of EVD survivors.⁴⁵ In addition, the focus on drugs may mean that these resources would only be available to rich countries or privileged persons in Africa and not everyone else (Pollack, 2014). Post-epidemic, there is a competition to conduct clinical vaccine trials in the affected countries (Kennedy et al., 2017). However, there is still a concern about whether poor people will benefit once these drugs are made available (Sendolo, 2015).

1.7 Summary

Despite years of development and humanitarian interventions, Liberia's and Sierra Leone's health systems were still fragile and vulnerable to a disease outbreak. Section 1.2 described the diversity of aid resources and how this shaped health policies in recipient countries. This gives an understanding of supply-side challenges and priorities of aid providers. Aid had evolved over the years to a neoliberal economic ideology that has also impacted how health interventions are conducted, like targeting only a few health issues (Johnston, 2015; Kickbusch, 2005; Mustapha, 2006). Although the WHO is the only international body that has a mandate on health, the plurality of actors, priorities, and aid resources has distorted low-income countries' healthcare systems to prioritize development on a few quantitative indicators (Chorev, 2013) rather than horizontal healthcare system strengthening to bring UHC, which is the WHO's position (World Health Organization 1978a; 2018d).

The next two sections discussed Liberia and Sierra Leone, where Liberia was a model for post-conflict recovery and Sierra Leone was not. These sections dissected the good governance reforms: state-building, macroeconomic reforms, and post-conflict elections as a tool for democracy. In both countries, we see that there were system-wide challenges that were not being addressed by vertical reforms. Guttal (2005) says that implementing neoliberal economic and political orders ensured that these countries remain in a persistent condition of state failure, rather than rebuild lives. Additionally, rural-based non-state institutions, such as traditional leaders were largely excluded thus, asking whether these reforms penetrated to the community level (Adam and Dercon, 2009; Mulbah, 2018).

⁴⁵ The perceptions and ethics of experimental drug testing is a complex debate especially why these were only made available to Western volunteers. The director of Caprisa, an AIDS research center in South Africa responds to these criticisms, "It would have been on the front-page screaming headline: 'Africans used as guinea pigs for American drug company's medicine'," (Pollack, 2014).

Section 1.5 reflected on how most donor-led interventions impacted the countries. The supply-side of these interventions are meant to create state institutions that can govern for economic output but do not widely address socioeconomic factors (Gray 2016; Guttal, 2005; Mulbah, 2018; Pailey, 2017). This gap is important to keep in mind for the next chapter. It further discusses why externally-led policies do not always lead to long-term changes, using the theoretical framework of New Institutional Economics. It then extends the theory to look at social outcomes.

The last section introduced the 2014 Ebola epidemic and criticisms of the international community's response (Kamradt-Scott, 2015; McInnes, 2016; Moon et al., 2015; Nunes, 2016). This section analyzed the supply-side barriers and how this follows a pattern in global health governance. There was an "anemic" response (McInnes, 2016 p. 381), and ongoing challenges to get a plurality of actors who have different priorities, to cooperate in this public health emergency. Additionally, these strategies do not address the complex social etiology of disease and often rely on a biomedical paradigm. These are the outcomes of the neoliberalization of GHG in the last few decades, and it helps us to understand the literature on public health emergencies in the next chapter, section 2.6. This literature tends to feature biomedical resources as resolving both supply and demand barriers. The last section in the next chapter discusses the demand-side barriers during the EVD outbreak, and this is where the thesis contributes to the debate on this phenomenon.

CHAPTER TWO: Theoretical Framework and Literature Review

Exploring the gaps in the literature and developing an approach to fill the gaps.

2.1 Introduction

The central question this chapter examines is how do rural-based institutions govern and what are their impacts? Institutions are the shared norms and rules that people abide by (Oström et al., 2001). In sub-Saharan Africa (SSA), the customs and laws governed by paramount chiefs, chiefs, clan leaders, councils, monarchs, youth leaders, and secret society leaders are collectively called traditional local institutions (TLIs). The thesis broadly fits into two debates, a theoretical debate on the governance and outcomes of traditional leaders (Acemoglu, Reed, and Robinson, 2014; Baker, 2007; Baldwin, 2015; Casey, Glennerster, and Miguel, 2012; Dia, 1996; Pande and Udry, 2005; Sesay, 2019; Tokpa and Yengbeh Jr., 2012; UNDEF, 2014; Unsworth, 2010). And the empirical debate on local governance of the 2014 Ebola epidemic (Abramowitz et al., 2015; Boland and McKay, 2018; Enria, 2017; Parker and Allen, 2018; Parker et al., 2019; Perry and Sayndee, 2017; Richards, 2016; Van der Windt and Voors, 2020; Wilkinson et al., 2017). A market approach examines how institutional quality impacts economic growth (Gray, 2016; North, 2003), however, information failures and social costs may be addressed by TLIs for social outcomes. Thereby extending the original framework of institutional quality. Thus, a review of potential market failures during the outbreak such as rumors, misinformation, and 'risky' behaviors reveals that aid resources alone did not address these demand-side barriers. Rather, these are governed by community leaders.

The first three sections: 2.2, 2.3, and 2.4 are the theoretical literature on institutions. Sections 2.2 and 2.3 discuss the New Institutional Economics Framework and how this has been used in development studies (North, 1990; North, 2003). Section 2.4 debates how TLIs contribute to or hinder development and democratic reforms. This section also includes specific studies on traditional leaders in Liberia and Sierra Leone. Section 2.5 examines market efficiencies for social outcomes, which is meant to move away from the wealth-maximizing approach of short-term gains in the original framework. The rest of the chapter critically reviews the literature on public health emergencies through Scott (1992)'s concepts of "public and hidden transcripts." In section 2.6, the public transcripts say donors and aid organizations address disease outbreaks mainly through clinical resources. The final section debates the community engagement strategies from the outbreak. The thesis holds there is a hidden transcript of communities self-organizing to resolve the epidemic.

2.2 Institutions

Institutional theory is an approach to studying anthropology, economics, history, international relations, law, political science, or sociology. There are different branches of institutional theory and the branch that the thesis discusses is the New Institutional Economics branch with key thinkers such as Douglass C. North, Elinor Oström, Ronald Coase, and Daron Acemoglu. Broadly speaking, this branch uses economic theory to understand social and legal norms. According to Coase (1998), these institutions govern the performance of an economy, which defines the new institutional economics approach. “Institutions are the rules of the game in a society or, more formally, are the humanly devised constraints that shape human interaction,” (North, 1990, p. 3). The people or team of individuals are defined as “organizations,” which are, “groups of individuals bound by some common purpose to achieve objectives,” (North, 1990, p. 5). Without these constraints there would be chaos, hence, the key aspect of institutions is the rules on what individuals can or cannot do.

While this is not the only definition of an ‘institution,’ according to Oström et al. (2001) it is the shared norms and rules that people abide by that all definitions of ‘institution’ have in common. Institutions have authority because of the shared belief and trust among people to follow the rules or laws that are governed by institutions. The rules are predictably enforced, and agents monitor behaviors and impose sanctions where needed (North, 1990). These rules can also be made to govern resources or ‘common goods’ as well as prevent overexploitation of common goods (Oström, 1990); or to oversee the delivery of goods such as health and education. By reducing uncertainty, institutions facilitate people’s engagement in complex forms of cooperation and agreements (North, 2003). This is based on a game-theoretical model, where it pays to play and, if one party does not cooperate, it will be punished by another party (enforcement). However, if it pays to defect or essentially violate the rules (corruption), then according to North (2003) this can be considered, “at the very heart of the failure of poor societies to develop,” (North, 2003, p. 6).

There are institutional failures such as market failure or government failure (Acheson, 2000). There are a variety of institutions and each can fail in getting people to cooperate or solve a complex problem. According to Acheson (2000), when it comes to

environmental resource management and conservation problems, four basic institutions have been proposed as a solution over the years: private property, government, communal management, and markets. However, he argues that none of these institutions on its own can be a general solution, as there is bound to be a conservation problem that each would fail to address. North and the remaining literature, except for Oström (common goods), use a market approach to discuss institutions and measure how institutions perform.

2.2.1 Polycentric Institutions

A branch from the new institutional economists is led by Oström (1990; 2010), she examines how institutions develop complex arrangements to overcome governing challenges. While trust and cooperation are the goals for every institution, there are complex motivational structures that drive human beings' interactions in today's societies. The rational choice model only explains behavior in a competitive environment for private goods and is not a broad theory to explain every decision of all individuals (Oström, 2010). Oström argues that reputation, trust, and reciprocity can overcome temptations of short-term self-interest (on-going cooperation, rather than just a one-off). Collective action in this sense is used in the broader political science term to refer to how people deal with social dilemmas, whether they are politicians or peasants.

2.2.1.1 Definition of Polycentrism

A polycentric institution is a multitier governing arrangement where “specific institutions can be designed at various levels of governance to meet specific governance challenges (V. Ostrom 1999). This framework involves institutional arrangements that go beyond ‘deconcentration’, as has typically been the outcome of decentralisation initiatives in Africa (Barkan 1998).” (Sawyer, 2004, p. 457). In these arrangements, each institution is responsible for governing specific challenges, such as a supply-side or demand-side challenge that will be explored below in section 2.7 and further in chapter five.

The literature on polycentric institutions tends to focus on how local communities cooperate to prevent overexploitation of communal goods.⁴⁶ This is different from the

⁴⁶ Public Goods are goods of a common concern. These goods are nonrivalry in consumption and nonexclusive. However, most goods have some partial exclusivity and rivalry (land, water, and livestock...etc.) these are ‘common-pooled resources’ and others, known as ‘club goods’ are non-rival but excludable (cable/satellite TV or intellectual property rights). See Brousseau, Dedeurwaerdere, and Siebenhüner (2012) and Smith et al. (2003) for further reading.

market approach (supply and demand factors) of the thesis, so this is briefly defined. Common goods (or common-pooled resources) are goods that are rivalrous, but nonexcludable, such as a river where anyone can fish from (nonexcludable), but two people cannot catch the same fish (rivalrous) (Brousseau, Dedeurwaerdere, and Siebenhüner, 2012). Therefore, renewable resources such as agriculture and fisheries, are usually examined in this framework. For example, land is a communal resource in West Africa that is governed as a common good through customary laws; traditional leaders allocate land for farming or other needs like building a school (Bulte, Richards, and Voors, 2018; Pande and Udry, 2005).

2.2.1.2 Building a Cooperative Environment

Rule enforcement is not about being authoritarian or heavy-handed with severe punishments, it is also about reciprocity. If an individual agrees to abide by a set of rules and it is contingent on others following the rules, then there will be social benefits. For example, Oström (1990) discusses the social dilemma of limited land for cattle to graze in Törbel, Switzerland. An ordinance was passed in 1517 to limit the number of cows a farmer can send to the pastures in the Alps, to prevent overgrazing on the land. This was still in effect through the late twentieth century, with the penalty of a fine. This is a law that requires everyone's cooperation for the common benefit of everyone's cows. If few people or no one cooperated, then the land would have depleted, and everyone would suffer because the cows would die. So, in a cooperative environment, an institution can guarantee reciprocity: those who cooperate share in the common benefits, while those who do not, will receive retribution, like a fine. However, Oström (1998) says that extreme cases of retribution would be a disaster, and, in some cases, it would not make sense to have retribution (e.g. cartels). If an institution has reciprocity as demonstrated above, then it can have a positive reputation of benefiting the cooperators and deterring the defectors.

Looking beyond the forestry, agriculture, or water systems, Sawyer (2004) argues that having a general government jurisdiction for service delivery is not enough for Sierra Leone and Liberia. Specific task jurisdictions that focus on the delivery of public goods should also be created locally and across provincial lines too, especially task-specific peacekeeping institutions across the borderlines that can prevent disputes from arising. This would extend to creating jurisdictions for education or health services, while including

traditional authorities to operate in their specific tasks, such as elders mediating interethnic conflict. These local and regional governing institutions should be constitutionally empowered, and this can transform a centralized autocratic state if implemented (Sawyer, 2004). This does not mean the state is eradicated, as state institutions are still needed to support local institutions (Mansbridge, 2014). Moreover, this is not decentralization as these institutions would not be an extension of the state, but rather semi-autonomous decision making entities.

Baldwin (2015)'s research⁴⁷ has similar findings on long-term cooperation as traditional leaders usually rule for life. She argues that short electoral cycles encourage the rational choice of short-term gratification as politicians will only be concerned with surviving the next campaign cycle and not invest in policies that extend beyond them. Chiefs are invested because they are known by name by their subjects. Acemoglu, Reed, and Robinson (2014), Adjei, Busia, and Bob-Milliar (2017), Baldwin (2015), Bulte, Richards, and Voors (2018) and Sawyer (2004; 2005b) agree that chiefs have greater social capital with citizens because the relationships are personal. However, Acemoglu, Reed, and Robinson (2014) view traditional institutions negatively, arguing that a type of social capital, patrimonialism, can lead to negative developmental outcomes. Oström (1998) explains how personal relationships through communication can build cooperation in local communities:

In noncooperative game theory, players are assumed to be unable to make enforceable agreements. Thus, communication is viewed as cheap talk (Farrell 1987)... From this theoretical perspective, face-to-face communication should make no difference in the outcomes achieved in social dilemmas. Yet, consistent, strong, and replicable findings are that substantial increases in the levels of cooperation are achieved when individuals are allowed to communicate face to face. (Oström, 1998, p. 6).

Oström (1990; 1998; 2010) argue for social benefits that are defined as material gains, such as access to land for economic opportunities. However, in a public health emergency, there is the social dilemma of protecting the common good versus restricting individual freedoms (Pellecchia et al., 2015). For example, the debates around quarantines (Enria, 2017), or implementing mandatory cremations (Perry and Sayndee, 2017). In section 2.7, the literature on the Ebola outbreak discuss rules and fines implemented to guarantee reciprocity (stopping Ebola). Additionally, the concept of polycentric governance is useful to understand how multiple institutions governed the outbreak in this case study. This is further discussed in chapters four and five.

⁴⁷ Baldwin (2015) does not write about polycentrism.

2.2.2 Institutional Quality

North (1981; 1989; 1990; 1991; 2003) has written about the impact of institutions on economic performance and how the performance of economies over time is shaped by the way institutions evolve. In the theory of production, North analyzes the role of institutions in the performance of economies by understanding the 'cost' of enforcing rights. These 'transaction costs' are the costliness of measurement and enforcement, such as transacting over property rights; and "property rights are the rights individuals appropriate over their own labor and the goods and services they possess," (North, 1990, p.33). Khan (2017) describes it as any social interaction and the rules are designed to govern those interactions to achieve better results. Institutions need to keep transaction costs low, and this depends on the type of technology employed, and thus brings us to the institution's role in production. The dilemma, according to North (2003), is preventing people from moving from personal (cooperation or following rules) to impersonal (abandoning rules) exchanges, but as the markets get bigger, it is harder and costlier for institutions to enforce these rules. Especially if someone can defect in one contract and move to another market without punishment. This argument is based on the rational choice model, that actors are self-interested or profit-maximizing individuals, and use this approach to solve collective action problems (Hall and Taylor, 1996).

Ideally, the state provides low-cost enforcement and protection of property rights through the judiciary system. However, states with weak institutions in place, create an environment of uncertainty where it may pay to defect or cheat, rather than play by the rules. Dreher, Kotsogiannis, and McCorriston (2009, p. 775) identify factors of institutional quality that drive economic agents underground: bureaucracy, regulatory discretion, rule of law, corruption, and a weak legal system. They say this is based on a pessimistic view of a leviathan government that exploits citizens. "Although economic agents may be willing to incur a reasonable fiscal burden, they are not willing to accept extortionate demands." (Dreher, Kotsogiannis, and McCorriston, 2009, p. 775). This is also part of the theoretical knowledge of the good governance policies discussed in chapter one and why fragile states were reformed in this manner.

However, it is crucial to note that North's notable work on institutions pioneered the field of cliometrics. Cliometrics is the study of history using econometric methods. This

framework was created to understand how societies historically achieved economic growth via high institutional quality. And, the growth model he used (the protection of property rights and low transaction costs) specifically follows a capitalist-led growth pattern as examined by Gray (2016). North believed that institutions provide the incentives aspect for investment (from an economic history perspective), and historical change of economies whether it is growth, decline, or stagnation, could be traced back to whether institutions were creating an investment climate. So, because this is looking at a very specific growth pattern, this framework has largely been used to explain the evolution of Western economies. While today, many countries around the world have adopted market-based macroeconomic policies, especially in the developing world through conditionalities imposed by donor organizations (Dreher, 2004; Stubbs et al., 2017b), this does not necessarily mean that they have developed the institutions to protect property rights (e.g. trademark, copyright, or wage laws) or to monitor and enforce rules for capitalist growth.

Therefore, North's work had implications for our historical understanding of economic change and our contemporary understanding of the development of low-income countries. Historically, the use of transaction costs as a determinant as to why some societies choose one institution over another can be misleading. A case in point is the comparison between the feudal system in Europe, in which labor from serfdom was used, and slavery in the United States. Milonakis and Fine (2007) explain that North argues that serfdom had lower transaction costs for the institution rather than slavery, hence why it was a rational choice for feudalism in Europe. However, the authors argue that high transaction costs of enforcement and supervision of slaves, make serfdom seem like a voluntary contract and ignores the repression, enforcement, and supervision that took place there too. So, sometimes relying on this interpretation of historical institutions can neglect real human or even inhumane experiences.

2.3 From Economic History to Economic Growth

The World Bank adopted North's key concept of transaction costs in the formulation of a definition for 'good governance'. This framework is used by the World Bank to create institutions that are conducive to market-led economic growth and indicators are used to measure institutional quality by 'weak' or 'strong' governance performance. These indicators are (a) voice and accountability, (b) political stability and absence of violence (c)

government effectiveness, (d) regulatory quality, (e) rule of law, and (f) control of corruption (World Bank, 2017). These institutions mirror Western countries' governance parameters and, these are presented as prescriptive to achieving positive economic change: that is growth. The 2002 World Development Report devises strategies to build institutions for market efficiency and productivity. However, according to the report, building and supplying institutions is only the first step; the next is to create change and demand for these institutions within the countries:

What limits market opportunities? Transaction costs from inadequate information, incomplete definition and enforcement of property rights, and barriers to entry for new participants. What increases them? Institutions that help manage risks from market exchange, increase efficiency, and raise returns. (World Bank, 2002, p. 5).

However, such a framework and especially its implementation are not free of contention.

As mentioned in the first chapter, vertical state-building policies led by the international development community focused on legitimizing and securing the state and not necessarily bringing human security. Human security is defined as access to food, health, education, jobs, and freedom from conflict; thus, these are the rights and freedoms at an individual level. This is vital to peacekeeping and nation-building, as human insecurity is a threat to the state too (Conteh-Morgan, 2016).⁴⁸ The good governance framework discredited state-led interventions, in favor of market-based ones. It has also been argued that these new institutions are not necessarily conducive to development, democracy, or human rights, but rather they facilitate the correct functioning of markets (Navarro, 2007). In some cases, good governance reforms have led to poor governance. In the case study of Mozambique's economic changes in the 1990s to the 2000s, World Bank researchers found "that foreign aid can induce corruption," (Hanlon, 2004, p. 747). Hanlon (2004) argues that despite good governance rhetoric, donors are prepared to tolerate corruption if these policies are implemented, and macroeconomic indicators show growth.

⁴⁸ The concept of human security is used in multiple disciplines. This nomenclature suggests 'securitizing' at the individual or community level. However, the concept of human security challenges the traditional notions of national security by prioritizing resources in a people-centered way. Therefore, it is a human rights approach and one that emphasizes freedom from conflict, freedom from hunger, or freedom from insecurity. Or in its broadest definition it, "Encompasses human rights, good governance, access to education and healthcare and ensuring that each individual has opportunities and choices to fulfill his or her potential. Every step in this direction is also a step towards reducing poverty, achieving economic growth and preventing conflict." (Annan, 2001, p. 1). Annan, 2001; Conteh-Morgan, 2016; Piccone, 2017; United Nations Development Programme, 1994).

However, Navarro (2007) and Hanlon (2004) were each published before the 2008 Accra Agenda for Action and the 2005 Paris Declaration respectively, which were agreements to align aid along the needs of recipient countries, rather than donor priorities. Thus, this may have changed aid governance in the last decade.

Rodrik (2004) also says that indicators of measuring institutional quality tend to favor the perceptions of investors, who generally feel positive when the economy is doing well. This often leads to the conclusion that high institutional quality is when investors feel private property rights are protected or the rule of law is upheld. However, we do not know which rule of law specifically or what the intended outcome of said law is. Rodrik (2004) gives the example of Russia and China; in the former, an independent judiciary protects private property rights, whereas until recently, private property rights did not exist in China. However, in the mid to late 1990s, investors gave China higher marks on the rule of law. Therefore, a private property regime is not necessary for high institutional quality, but a sense of safety and stability for investors. Likewise, relying on the perceptions of investors excludes other perceptions of institutional quality, whether the outcome is economic growth or something else. This is the second contentious point regarding both North's work and the 'good governance' framework deriving from it. Indeed, it appears that both adopt a narrow focus on economic growth specifically, which leaves out various important indicators of socioeconomic development. Nor do we fully understand how rule of law, in and of itself, leads to economic growth.

2.3.1 Developing Institutions for the State

Navarro (2007)'s concept of the economy as a pie, helps us visualize the difference between economic growth and socioeconomic development. Development policies like the Structural Adjustment Program (SAP) and Poverty Reduction Strategy (PRS) have largely focused on economic growth, and if we imagine the economy as a pie, these policies try to make the pie bigger. However, the problem is that socioeconomic development may not improve, even in economies that are growing. So, the question is whether everyone gets a bigger slice of the pie while the pie grows or if the growth means that a few people get giant slices, while the majority poor share the crumbs (Navarro, 2007). For instance, in Hanlon (2004)'s case study of Mozambique, he reports that the country indeed had the best-

performing economy in SSA, with 8.4% GDP growth⁴⁹ in the 1990s. But most of the Mozambique population did not share in that tremendous performance.

This brings us to the third contentious point, which relates to the way the World Bank has extended North's framework, by including free elections as part of its state-building strategy (World Bank, 2002). It assumes that elections are meant to discipline politicians and an electorate would not tolerate corrupt politicians. If elections are free and fair, then politicians will be held accountable. However, there is a difference between elections and democracy. Harris (2012), Mulbah (2018), Mustapha (2010), Mustapha (2016), and Pailey (2017) discuss how Liberia and Sierra Leone held elections in the transition from war to recovery, but this did not actually translate into democratic institutions. Mustapha (2016) says that democracy has not consolidated in Sierra Leone as the press is not free and industrial actions are usually met with police force. And, as noted before in chapter one, only half of Liberians feel they are living in a democracy (Pailey and Harris, 2017). Elections are sometimes followed by periods of violence, as well as corrupt funding of campaigns, however international agencies have declared Liberia and Sierra Leone's elections since the wars to be fair (Harris, 2012; Mustapha, 2016). Problematic, but fair. The World Bank (2002)'s report does not unpack democracy theories and what it means to have a democratic society to bring development and human rights, instead it focuses on elections to keep out corrupt politicians and freedom of the press to give information. This is a market-based analysis that the more information that is available, then voters can make informed decisions and elections are competitions to bring more desirable candidates. However, this analysis is limited, as shown in the Afrobarometer (2019) surveys in the prior chapter, there is quite a high tolerance for corruption in public administration.

The literature interprets this differently, such as a culturally-determined definition of corruption. Hellsten and Larbi (2006) say that Western perceptions rely on individualist cultural and moral obligations. However, in other societies, there is no separation in identity between one's professional and personal life. So, what may be perceived as corrupt in one society may not in another, especially where patrimonialism is used to govern. However, Pailey and Harris (2017) say that entering state politics is often a way to increase financial wealth in Liberia. It is not to generalize that Africans are more corrupt. Rather, since these

⁴⁹ Gross Domestic Product is the broadest measure of a nation's total economic activity; it is the market value of all final goods and services produced. See Bank of England (2018) for further reading.

state institutions (implemented via development efforts) are not seen as legitimate by the people, then corruption and even state-capture are expected as politicians are not accountable to the local constituency, despite having elections.⁵⁰ In other words, the assumption that elections will keep out corrupt politicians did not consider the local constituency's views on corruption or the position of state office. And this assumption is not only misplaced in SSA, but also Western countries such as the United States.⁵¹

Therefore, holding elections becomes a ritual to give a sense of local ownership and civic participation in SSA, but liberal democratic values have not consolidated (Carothers, 2002; Harris, 2012; Omotola, 2010; Mustapha, 2016; North et al., 2015). In the worst-case scenario, elections are used as a cover for authoritarian regimes.

North extends the framework of institutions to further examine problems in development, specifically through the concept of Limited Access and Open Access Orders (North et al., 2015). Limited Access Orders (LAOs) are defined as the natural state where leadership is built through personal relationships and face-to-face interaction. However, hierarchies of elites are formed (religious, military, economic, and political) and they control access to resources through rent-creation.⁵² This also helps to control violence in a society, because elite rents are reduced if violence breaks out (North et al., 2013). This also means that these societies will be more sensitive to change as dynamics could result in violence, such as violent clashes after an electoral cycle. Open Access Orders (OAOs) proscribe violence to an organization, such as the military or police, and have an impersonal citizens' relationship. In this state, individuals can pursue their economic interests through organizations. Rents do exist in this order but are temporary since there will be increased competition. The social order is maintained through the interaction of competition,

⁵⁰ See Table 1.15 on p. 36, on the perceptions of political leaders in office to serve their own ambitions and not the people.

⁵¹ Many Americans believe that corruption is widespread through government and the 2016 presidential elections saw accusations of conflicts of interest and corruption on the leading candidates: Clinton and Trump (Devlin-Brown and Dee, 2017). Nonetheless, Rothstein (2016) argues that Trump was elected because he promised to fight against 'favoritism' as a form of corruption, as White Americans believe that racism against Whites is a bigger problem than racism against Blacks or Latinos. In other words, that ethnic minorities were being 'favorited' in government policies. Thus, Trump's well-known business connections in foreign countries, refusal to reveal his financial history through tax returns, and refusal to divest himself from his companies if he won, did not hinder his success.

⁵² In modern economics, rent is the surplus amount paid on top of the actual price of a good or service. This is not the same as 'renting' a property or asset. An example of economic rents would be a waitress earning a tip or someone accepting a bribe. Therefore, rent-seeking/creation behavior is when a policy is manipulated to make a profit. See Rogers (2016) on the manipulation of Sierra Leone's housing policy, which uses international aid funds to build luxury style homes; this excludes the majority poor and does not address homelessness as it was intended.

institutions, and beliefs (North et al., 2013). OAOs can handle change better because their organizations and institutions are freer (not controlled by elites) to adjust when needed.

OAOs are high-income countries like the United States and those in Western Europe and LAOs tend to be low-income countries like Sierra Leone and the Democratic Republic of Congo. However, it is noted that exceptions to these categories exist, such as Singapore, which is a high-income country but is classified as an LAO for being less democratic or authoritarian (North et al., 2015). LAOs can also transition, like Mexico or Korea in the 1990s. North et al. (2015) are also critical of the Washington Consensus approach to development and feel that the failure in policy is because donors saw low-income countries as incomplete OAOs and not as societies purposely structured to prevent violence as an LAO (North et al., 2015). This is similar to Reno (1995)'s analysis regarding access in the patrimonial state, where he discusses President Taylor's use of foreign and elite networks to maintain power and exclude any potential or real rivals in Liberia. However, Reno (1995) argues that patrimonial states use systematic violence to maintain the social order (like an LAO) instead of a legitimate bureaucracy (like an OAO).

North et al. (2015) argue that policy recommendations need to be nuanced and take local context into account, as these policies only focus on entry into the market and increasing competition, and governance indicators are designed to measure OAO institutions in LAO countries. In terms of democracy, through the nine case study countries in this work, the electoral process in the global south is not the same as democracy in the Western world. Also, moving to democracy too quickly can destabilize LAOs, but holding elections can be a stabilizing ritual, even if the results do not express the will of the people. The authors argue that this could be a trade-off, but elections in LAOs can still fail to transition a country to an OAO and may just perpetuate the status quo.

The cases cited such as Bangladesh, the Democratic Republic of Congo, and Korea in the 1960s, show that there should not have been a race to hold an election, but institutions should have been in place first; even if these elections are unfair (North et al., 2015). This conclusion contradicts the World Bank (2002) report that increasing electoral competition would bring democratic reforms. It also supports Pailey and Harris (2017)'s Mulbah (2018)'s, Mustapha (2016)'s arguments that state-building initiatives did not do enough to build a nation and bring reforms to the community-level.

However, North et al. (2015) conceptualizes economies in a linear fashion, as the purpose of this work is to think about how development policies can transition countries from limited access to open access orders. This places OAOs as the ideal for all countries to achieve, even though there are exceptions in his case study, such as Singapore (North et al., 2015). This country has a strong economy and strong social development trends, but politically, it does not have a liberal democracy like the Western world. Other countries that are missing from his case study include wealthy Middle Eastern countries and notably China. In fact, some African studies scholars argue that SSA should consider the 'Chinese model' to development (Amtaika, 2017). Therefore, when we factor in these exceptions, we see a wider spectrum of countries that have achieved economic growth and social development but without opening access to the individual. And while North's conceptual model focuses on the internal factor of building strong institutions, it leaves out other external factors that could affect economic growth such as trade imbalances that leave low-income countries as peripherals in the global market (Mustapha, 2006; Mustapha, 2010; Pailey, 2017).

2.3.1.1 When 'Development' Delegitimizes State Institutions

North et al. (2015) say that with respect to democratic reforms, LAOs are less flexible to change than OAOs. The changes that the authors are discussing, are the development policies discussed in chapter one. These were largely externally-led and do not necessarily reflect how dynamic or static institutions are in LAOs.

The literary debate on this has centered on state institutions, and Gray (2016) says that these institutions have been built for the governance of private capital accumulation, meaning for economic growth. "Formal institutions, the most important of which are the protection of private capitalist property rights, are broadly aligned with and sustained by the social, economic and political power that capitalists have, based on capitalist profits," (Gray, 2016, p. 70). However, designing neoliberal state institutions for economic growth can raise a problem with legitimacy and authority.

In general, the branches of institutional theory, do not question the legitimacy of institutions, as there is an assumption that these are institutions that are organically grown within the society or at least willingly adopted. However, as mentioned in chapter one, on the Afrobarometer surveys and in the upcoming section 2.4 on traditional institutions in

West Africa, there are higher rates of distrust and dissatisfaction with the state and judiciary processes and some preferring non-state institutions.

According to Adjei, Busia, and Bob-Milliar (2017), the legitimacy and authority of the Western state are derived from a legal-rational concept. This means there is an impersonal legal system that society members adhere to and obey. They distinguish this from traditional authority, in which chiefs claim their authority on traditional customs that have always existed. The obedience is aligned to the person occupying the chieftaincy. This means that traditional leaders rely on personal relationships and reputation to gain trust. Trust and reputation are what bring people together to cooperate (North, 1991; North, 2003). Thus, any type of state-building should include local institutions, as most people in the rural areas are already socialized into traditional customs. Or, in other words, they are 'institutionalized' into the chieftom institution and any development initiative that does not include them could lack legitimacy (Adjei, Busia, and Bob-Milliar, 2017).

Pailey (2017) argues that the Liberian government followed the donors' strategy of a "peripheral capitalist path to development" (Pailey, 2017, p. 653) by neoliberalizing services and retrenching the state. They were not supported to build a strong healthcare system as a way of legitimizing themselves in the eyes of the constituency.⁵³ When the 2014 Ebola epidemic began, many did not believe the government's messaging and therefore, "twilight institutions" arose, which consisted of collective action and individuals who had public authority (where the government did not) to assist.

Sawyer (2004) argues that in the process to end the civil war in Sierra Leone and Liberia, institutional mechanisms of peacebuilding were not implemented in the post-conflict governance reforms. Both countries have returned to overcentralized administrations with patron-client networks. There have been high-level reconciliation and international court trials for high-profile actors such as Charles Taylor or Foday Sankor; but reconciliation and peace need to be implemented at all levels of governing. Otherwise, the region may continue to be unstable. "The tendency to see constitutions as predetermined legal moulds can be a source of flawed institutional arrangements and eventual institutional failure. Each society has to create its constitutional paradigm, and craft appropriate institutions for democratic governance responsive to its circumstances." (Sawyer, 2004, p.

⁵³ However, Keith and Cadge (2010) argue against this and say that health services were prioritized by the Liberian government to strengthen the health system horizontally. This was mentioned in chapter one, section 1.3.4.

454). This supports Adam and Dercon (2009)'s warning from chapter one, about reforming existing institutions for economic growth or ignoring them because they do not fit the external methods of validation.

North (2003) says that reputation lowers as markets evolve since it is harder to maintain personal relationships of trust when these markets expand (hence the need for low transaction costs to enforce rules). This may explain why neoliberal state institutions that are built with qualities that emphasize economic growth but not social development or welfare, have legitimacy problems. Therefore, vertical state-building policies that exclude non-state local institutions (Adjei, Busia, and Bob-Milliar, 2017; Sawyer, 2004) or fail to deliver services to the people may lack trust and reputation (Pailey, 2017). This point will be evident in chapter four's interviews with key informants.

2.4 Traditional Local Institutions (TLIs)

The extension of North's framework of New Institutional Economics into the good governance development policy to build new institutions for economic growth has not always brought strong development trends (Gray, 2016). However, the original framework is still useful for alternative paradigms, where institutions are rooted in traditions or customs and derive legitimacy and authority from this. The institutional debate has not thoroughly examined traditional local institutions (TLIs) like paramount chiefs because they have been seen as an impediment to modernization (Fanthorpe, 2001; Jackson, 2011), or perhaps because this institution is not part of the capitalist growth model (Gray, 2016). There is one aspect of the framework that can be extended to analyze this and that is the concept of institutional quality.

This section analyzes the literature on traditional institutions and how governance is assessed. The theoretical debate is synthesized in section 2.4.6 and this is the first of two debates that the thesis fits in. Then section 2.5 discusses how institutional quality can be extended to a new framework to assess how TLIs could have good governance.

2.4.1 Definition of TLI

This thesis uses these definitions of traditional, community, and state institutions for analytical purposes that will be used throughout the thesis. Traditional Local Institutions (TLIs) are the norms and customs that are governed by traditional leaders, termed

paramount chiefs, chiefs, clan leaders, councils, monarchs, youth leaders, and secret society leaders.⁵⁴ Religious leaders are not included because within the case study many chiefdoms are secular, but that is not universal across all societies. Community-level institutions are norms and behaviors in local communities, this is broader than traditional leaders as it can include community organizers or other respected members. State institutions are rules and regulations governed by the state.

2.4.1.1 Women in the Definition of TLIs

Some scholars say that traditional authorities are gendered and leave out women, however much of the literature on traditional authorities focus on the chiefdom and not the broader political elite (Acemoglu, Reed, and Robinson, 2014; Beekman, Bulte, and Nillesen, 2013; Beekman, Bulte, and Nillesen, 2014; Hanlon, 2005; Jackson, 2005; Peters and Richards, 1998; and Richards, 2005). Secret societies are included in this definition because these are prevalent throughout West Africa and have political and social roles in the institution (Harris, 2013). The male society is called the *Poro* in the Mano River region (Little, 1947; Little, 1949). The women's secret society is called *Sande* in the Mende ethnic group or generally known as *Bondo* (Moran, 1989). There are other societies and single-sex systems though, for various ethnic groups, like the *Gbangbani* for Limba boys (Goguen and Bolten, 2017).

There are various studies examining power through the female societies. For example, in Liberia the *Sande* organized a public protest regarding the allocation of land for commercial farming activities (cash crops and normally performed by men), which left less land for subsistence farming (labor performed by women). In some places, female leaders are elected along with a paramount chief or king or in areas where there are no secret societies, there exists a single-sex system for collective action (Moran, 1989). Among the Mende and Sherbro ethnic groups, women could assume the status of paramount chief by inheriting it from their husbands or via elections autonomously (Day, 2012). At the time of Hoffer (1972)'s research, about 10% of chiefdoms had a female leader. The author says that women are respected and seen as active and able for leadership roles, which contrasts with Western culture that sees women as passive and unable due to "biological disabilities of reproduction" (Hoffer, 1972 p. 163). However, Moran (2012) says that the patriarchal

⁵⁴ Full definition was discussed in the introduction on page xiii.

system still operates in the overall society and is also reflected in the *Sande*, *Poro*, and other secret societies. For example, in Sierra Leone, women have been marginalized in the customary courts, although this varies in the north and south (Jackson, 2011).

Furthermore, the broad inclusion of stakeholders in this definition reflects the traditional political decision making processes that include various stakeholders, such as the chiefs' councils, women leaders, and youth leaders (Oosterhoff, Mokuwa, and Wilkinson, 2015).

2.4.1.2 The Definition May Understate Power

Unsworth (2010) says that TLIs and state institutions can interact and impact each other's realm. For example, in Sierra Leone and Liberia, TLIs have been formalized in the years since the conflict period as part of good governance reforms. In Sierra Leone, paramount chiefs are part of the national parliament but do not have jurisdiction in Freetown (Conteh, 2013). In Liberia, paramount chiefs have been decentralized to the sub-district levels and incorporated into the executive branch (Tokpa and Yengbeh Jr., 2012).

Ubink (2008) examines the authority and power of chiefs across many African countries, and like Adjei, Busia, and Bob-Milliar (2017), she argues that traditional leaders enjoy cultural legitimacy that is based on tradition, but also play a role in dispute resolution and they are an alternative where state institutions are weak or failing. Likewise, in Iyanya (2018)'s case study of the Igede in post-independence Nigeria, this minority ethnic group used the democratic processes to elect an Igede traditional leader to represent them at the local level. Thus, although these are termed, 'traditional' they are dynamic and modern institutions, governing in contemporary politics.

The organizations of paramount chiefs are elite and powerful groups that have thrived for centuries. The ruling families or chiefs control land resources in many places and are vital in local and national politics. The definition of TLIs distinguishes them from the state institutions that have been created through years of vertical state-building; however, this definition is not completely accurate, as chiefdoms in Africa and Asia have been manipulated through colonialism and postindependence, by the state.

It also distinguishes them from the literature on collective action, as Scott (1992) and Oström (1990) view micro-level mobilization and rulemaking as a collective action, whether in Scott's view to subvert power from the dominant or in Oström's view to prevent

overexploitation of natural resources. However, these organizations are not an oppressed minority, nor will TLLs always come together with a shared interest or purpose. They are a ruling political class that has historically received less attention in the literature, than state institutions, when it comes to policy-making and development. This has latterly changed with the involvement of chiefs in community-based donor programs (Chhibber, Laajaj, and Bain, 2006; UNDEF, 2014). However, sometimes donor programs have the intention to create social and political change, but with mixed success. This last point is explored in the next section.

2.4.2 TLLs in Local Development

Fearon, Humphreys, and Weinstein (2009) examine the effectiveness of a Community Driven Reconstruction (CDR) project in northern Liberia in increasing social cohesion. The establishment of CDRs in post-conflict countries is to “support the establishment of new local institutions in order to promote social reconciliation,” (Fearon, Humphreys, and Weinstein, 2009 p. 287). The findings suggest the CDR program improved community cohesion; the treatment communities raised significantly more money than the control communities. Social cooperation was high across all villages in the sample, 71% of households contributed the maximum amount in treatment communities, while 62% contributed the maximum amount in control communities.

Thus, while brief outside intervention can make changes to a community’s cohesion, the authors note that it was done without fundamental changes to either the structure of economic relations or to more macro-level political processes. This could also explain why the direct impact of the CDR program on welfare was modest as it did not change the power structure, so the impacts of long-term development or even democratic governance are still unknown.

Casey, Glennerster, and Miguel (2012) discuss a community-driven development program in Sierra Leone that was created to promote democratic decision making, transparent budgeting, and participation of socially marginalized groups. This was to foster local coordination and cooperation through the setup of village development committees that would decide and execute development projects. However, the results showed a limited impact on institutional change. According to the authors, democratic decision making did not spill over into village life, nor did the program train villagers in project

management skills to take on other opportunities after the program ended. Also, traditional authorities maintained their positions in these development committees too. The authors mention a paradox; this project was meant to implement, and ideally institutionalize, a participative democratic process to local development. However, in some places, project implementation was expedited when TLIs were leveraged.

Baldwin (2015) analyzes this paradox by conceptualizing traditional leaders as development brokers. Although they are selected by a limited electorate and rule for life, they have more incentives to deliver public goods. Therefore, they could be beneficial for democracies in SSA. Drawing on her fieldwork in Zambia, she explains that elected leaders in state institutions often need community cooperation to engage with local development projects. They maintain good relationships with traditional leaders as they would have the authority to organize communal labor, like making bricks to build a school. Baldwin (2015) says that these leaders are also self-interested actors and this research is not to romanticize them, but they have deep social and economic interests in the development projects since they live in these communities too.

Van der Windt et al. (2018) say that these programs (Casey, Glennerster, and Miguel, 2012; Fearon, Humphreys, and Weinstein, 2009), were designed to constrain the power of traditional authorities and empower local people. However, through structural modeling, they find that support for state institutions do not replace support for TLIs. Rather, these are complementary and subject to external shocks, such as weather episodes or conflict (Van der Windt et al., 2018). This means that support for one authority may rise or fall if the value in another one changes. This finding builds on Baldwin (2015)'s argument of state and traditional authority collaboration.

Thus, TLIs may have more incentives to make upfront investments in local projects. Or as Adjei, Busia, and Bob-Milliar (2017) argue development projects are not seen as legitimate unless TLIs are involved.

2.4.3 Customary Law and the Traditional Justice System

In the socio-legal debate, many African countries are pluralistic legal societies, where traditional leaders govern customary law and state leaders govern received law⁵⁵ (Allott,

⁵⁵ Received law is defined in the literature as the common law (in some former English colonies) or civil law system that was implemented in the country, depending on the colonial history (Ndulo, 2011). Some scholars also consider Islamic or Sharia law to be a received law as it is not based on local traditions.

1984; Frémont, 2009; Maimela, 2019; Ndulo, 2011). In countries with large Muslim populations, there is also Islamic law. However, some scholars say this is separate from customary law (Allott, 1984; Ekhaton, 2019; Ogwurike, 1966); while others examine this and include it, like in the case of northern Nigeria where it was once part of customary law (Ladapo, 2008). Thus, while customary law is used very broadly to discuss the traditional unwritten African legal system, the laws greatly vary from one group to another (Allott, 1984; Bwire, 2019; Ndulo, 2011; Ogwurike, 1966). This term is a description that covers many different legal systems (Ndulo, 2011), but for the purposes of this thesis, a brief description and analysis is offered here.

These systems are based on local ethnic and cultural groups, and usually, only operate in the area occupied by the ethnic group or in a case that involves a group member (Ndulo, 2011). However, there are some generalizations on how customary law operates across Anglophone and Francophone African societies. Bwire (2019) writes that the legal philosophy of traditional African justice is a restorative justice that emphasizes restitution and is not really about punishment. Hence, the purpose is to heal community relationships that was harmed by a crime or a dispute. In Sierra Leone, Sesay (2019) also observes that the traditional justice system and local bylaws, which evolved exogenously from the state, are still favored by local communities to resolve social infractions, rather than going through the state justice system, which is slow and punitive.

While state institutions are slow and out of reach for many rural dwellers, authors on this side of the debate argue that these legal philosophies reflect the social and cultural mores of the people. For example, in examining corruption in Nigeria, Ekhaton (2019) argues that traditional oath-taking and customary courts should be incorporated in anti-corruption measures. Although these are currently tried in the state criminal justice system,⁵⁶ the evidence suggests that community members prefer traditional structures to curb crime. Ekhaton (2019) argues that belief in traditional spiritualism is high, despite many who identify as Christian or Muslim. Therefore, the fear of a curse or other negative spiritual repercussions could help deter crime.

For example, there was an incident where a market in Benin City caught on fire and afterwards, people looted the property. The traditional leader invited the chief priest to

⁵⁶ Ekhaton (2019) says that Nigeria does not allow customary courts to try criminal law cases, so one would have to be created under the constitution.

publicly place a curse on the criminals. By the next morning, the looted goods were returned (Ekhatior, 2019). The author argues that if traditional oath-taking are allowed in criminal cases, just like a statutory oath, or if one could take an oath in front of traditional rulers, this could improve anti-corruption efforts.⁵⁷

Customary law also holds communitarian values, whereas (English) common law tends to prefer the individual (Frémont, 2009; Maimela, 2019; Mqeke, 1996). Thus, it is important to note that the New Institutional Economics theory emphasizes individual property rights for good governance and economic growth, which is based on common law too. Hence, the need to extend the theory to understand governance of TLIs as not being (poor or low) institutional quality, but rather, based on group or communitarian-oriented values. According to Frémont (2009), the most important value is the preservation of social peace in communities, hence, the restorative justice model discussed above. However, the rights of the group are how individual human rights (including gender and children's rights) are framed in customary law. Maimela (2019) says that the group interest is key to survival and growth in SSA, and individuals are more empowered when they are in a group instead of advocating alone. In examining Francophone Africa, Frémont (2009) says that many of the rights in the 1948 Universal Declaration of Human Rights existed in pre-colonial Africa such as freedom of religion, freedom of expression, freedom to participate, and universal education for children. In terms of children's rights, these came with a "paternal authority" of the group to be responsible for children's education (Frémont, 2009).

Therefore, when we examine the local response to the Ebola outbreak in section 2.7, the literature briefly touches on this concept of rights of the individual versus the group during a public health emergency (Pellecchia et al., 2015). This is especially concerning among critics who feel that the passage of bylaws were authoritarian and restricted individual rights (Boland and McKay, 2018; Enria, 2017; Wilkinson et al., 2017). These authors above would have likely argued that the bylaws are based on the social mores of collective integrity and social cohesion.

Indeed, Ozoemena and Hansungule (2009) also argue that traditional systems were equal, and in some instances, surpass current international and national legislations on

⁵⁷ Since criminal court cases cannot be tried in customary courts in Nigeria, the traditional oath would be done in front of a traditional ruler. However, the downside is that many people would "opt" to take the oath instead of going to court. Ekhatior (2019) argues that the state judiciary system is very slow and ineffective at trying corruption cases anyway, and radical reforms (in traditional and state procedures) are needed to tackle corruption.

human rights. The authors say that gender justice is not alien to customary law and that common law has sometimes acted detrimentally against women. For example, in the dissolution of marriage in the Igboland, neither party is entitled to the other's property. However, in common law proceedings, the contributions made by the woman via subsistence labor is quantified differently than what was originally intended under customary laws (Ozoemena and Hansungule, 2009).

Moreover, on examining the atrocities of European settlement and legal institutions in Africa, Maimela (2019) argues that for most of the history of South Africa, the imposed European legal system did not guarantee human rights for Black Africans.

However, Bennett (1994) argues that since customary law is based on patriarchy, much like common law, there still needs to be modifications to promote gender equality (just as there was with the 1993 South African constitution to add an 'equality clause'). These suggestions are in specific areas on the rights of women in marriage, divorce, and guardianship. Additionally, Bennett (1994) suggests that as a temporary fix, in judicial cases where customary law may potentially discriminate, common law can be applied for the decision. Thus, Bennett (1994) does not argue to abolish customary law, but rather to reform it.

Finally, customary law is evolving and in West Africa it is codified into state law (Chieftaincy Act, 2009; Local Government Act, 2015; Local Government Act of 2018, 2018; The Local Government Act, 2004). Sanders (1987) asks how 'customary' is customary law in today's context? As not only do customs naturally evolve, but also SSA has a long history of Western influence during the colonial and post-independence eras. For instance, the development reforms to change local institutions for 'good governance'. Additionally, Ogwruike (1966) writes that state courts are also turning customary law into state law via verdicts, demonstrating the dynamics of TLLs. Therefore, it stands to argue whether the traditional and the modern are so distinct. The next two subsections give insight into TLLs in their local dynamic political contexts.

2.4.4 TLLs in Liberia

Indigenous people were largely excluded from citizenship rights until President William Tubman's administration in the mid-twentieth century. Article 56 (B) of the 1986 constitution of Liberia, allows for paramount chiefs, clan chiefs, and town chiefs to be

elected by the constituency (Johnson, 2016). However, there has not been an election for these chiefs since 1986. Instead, most paramount chiefs and the local commissioners have been appointed by the President (Bulte et al., 2012; Government of Liberia, 2018). The National Election Commission has focused most of its resources on the presidential and legislative elections, while these local authorities have ascended through selection of the executive office or those appointed officials acting on behalf of the executive mansion (Johnson, 2016).

Consequently, some argue that the civil war was primarily led by young people who felt excluded from opportunities within traditional and state institutions (Mulbah, 2018; Tokpa and Yengbeh Jr., 2012). Traditional leaders tend to be older and male, but state leaders fall into this category too, while most are also Americo. This raised concerns that state-building and good governance reforms that are supposed to be more democratic and bring socioeconomic development to the most vulnerable, also exclude marginalized populations such as women, youths, and indigenous ethnic groups. According to Beekman, Bulte, and Nillesen (2013), Liberian society is hierarchical with evidence that sometimes chiefs misuse their status and power for personal gain. Especially in their experiments to detect corruption, they speculate that resources may be misappropriated to feed into patron-client networks (i.e. patrimonialism). Today, chiefs are nominated by elders in the community, then elected by community members, and this is approved by the government. However, since there have not been chieftom elections, some believe that traditional leaders are not always accountable to their constituency (Johnson, 2016).

Experimental research in rural communities shows that corrupt chiefs can undermine key economic activities (Beekman, Bulte, and Nillesen, 2013; Beekman, Bulte, and Nillesen, 2014). These experiments build on the theory that poor governance, in the form of corruption, can undermine local development and economic growth. Corruption is measured in a forensic economic approach of looking for missing expenditures; in this design, weighing seeds before and after storing them in the chiefs' home. This is called a gap measure (Beekman, Bulte, and Nillesen, 2013). If the bag of seeds weighed less than before bringing it to the chiefs to store them, then the missing amount is considered diverted. In this study, 36% of observed communities had missing seeds before being distributed to community members for an agrarian project. In these communities, members were also less

likely to engage in trade activities and they planted fewer crops, which affects economic development.

In a separate experiment for public goods, Beekman, Bulte, and Nillesen (2014) find that communities with corrupt chiefs will invest less to provide a public good or service. This was designed as a game where random and anonymous community members were given tokens assigned a monetary value and could determine how much to put into the public pot for a good or service and how much to keep for themselves. Communities with corrupt chiefs had lower voluntary contributions to the public pot. However, they are also aware that the seeds could have been diverted into patron-client networks to fortify the position of the chief by giving to the neediest. Thus, they do not address if lower voluntary contributions could be due to those in need already receiving distributions from the chief. The authors argue that in this sense, having a corrupt chief was like paying a distortive tax. Overall, these experiments build on the theory that the quality of institutions is correlated with economic growth and investment. Corruption, which is an indicator of poor institutional quality can hinder growth.

Baldwin and Mvukiyehe (2015) examine sectoral and electoral processes that took place for clan chiefs that were eliminated at the end of the war (death or left). The study shows that when elections are introduced to traditional institutions, this may decrease collective action and public good provisions. This may be because elections end up creating a parallel system of governing, rather than replacing traditional institutions. Therefore, elected leaders must collaborate with traditional leaders to organize collective action and contributions. The authors say that other field experiments show higher contribution levels (e.g. taxes), but that is when participants get to vote on the rules beforehand. In this scenario, the rules were imposed on the control groups through an external process with little preexisting legitimacy in these communities (Baldwin and Mvukiyehe, 2015).

In the debate of modernizing Liberia, questions have arisen regarding the relevancy of chiefs. There is a view that traditional authorities are not relevant, outdated, and may even hinder development. As well as there is another perspective that despite its weaknesses, traditional leaders are indispensable (Tokpa and Yengbeh Jr., 2012). Tokpa and Yengbeh Jr. (2012) also identify a third approach, historically, chiefs have been used as an extension of authoritarian rule (either colonial or in Liberia), but today they can promote democratic governance. However, state reform of TLIs may not always improve its function;

the Liberian government created ‘native or tribal courts’, which tend to be more authoritarian or coercive than the house palavers (customary law courts) that exist in town quarters (Sevareid, 1993). The house palavers are favored, as these aim for reconciliation rather than an adversarial legal procedure because positive relationships among the clan are more important than “the vindication of private rights” (Sevareid, 1993, p. 75).

Former Liberian politician and scholar, Amos Sawyer (2005b), argues that Liberia can benefit from polycentric governance where there are multiple institutional layers. In other words, including non-state institutions in the development and democratic processes for self-governing. This concept would not be unusual for Liberia as traditional governance was historically led by an indigenous deliberative democracy (Mulbah, 2018). Therefore, Sawyer (2005b) would argue that state-led reforms of TLIs in Liberia is not necessary, as these local institutions can self-govern.

Indeed, despite the prior research above, demonstrating corruption as a present factor in some Liberian TLIs and alledged cause of the civil war, they are still popular. Logan (2013)’s findings show that age and education had significant effects as the more educated showed less support, but younger people tended to have more support for TLIs. This challenges past assumptions of young people feeling disenfranchised by TLIs and the assumption that support for traditional rulers correlates with (perceived) failings of the state. Many respondents felt that traditional rulers had an important part in modern society and some even felt that they should play a bigger role too.

2.4.5 TLIs in Sierra Leone

Richards (2005) and Hanlon (2005) discuss abuse and corruption of the paramount chiefs from the colonial days and trace uprisings against the chiefs as far back as 1955. Richards (2005) traces this abuse of authority to 19th century colonial laws that gave the chiefs the power to induce forced communal labor that had been in effect until the contemporary era. However, Fanthorpe (2006) argues that these historical practices should not be confused with today’s communal labor, which often focuses on projects that benefit the community such as schools, roads, and controlled brush fires. Richards (2005) says that customary laws should be reformed as well as the chiefs’ courts. He argues that the state’s judiciary system should have oversight of their rulings, but Sawyer (2008) says that this is problematic for two reasons. First, the customary laws are still highly valued among the

population, and second, state institutions are not trusted. For example, the traditional justice system and local bylaws evolved exogenously from the state and are used today to resolve social infractions, rather than going through the state justice system (Sesay, 2019).

Therefore, the donors' approach to post-conflict development was to recommend generic liberal political and economic reforms without considering why the rural poor may prefer nonliberal forms of governing (Fanthorpe, 2006).

Richards (2005) and Hanlon (2005) argue that the chiefdoms tend to be autocratic and question if reinstating them in post-conflict recovery would hinder development, especially for marginalized groups. However, at the time of writing, the authors did not consider other TLIs where women and youth gain power and social status. As mentioned in section 2.4.1.1, secret societies coexist with chiefs and play a major role in governance and politics at the local and national levels. Chiefs are usually members if not head, of the secret societies and so are elected politicians (Conteh, 2013). However, customary law in some parts of the country arbitrarily defines youth (anyone under 35) and this can limit opportunities (Fanthorpe, Lavali, and Sesay, 2011).

Much of this debate has focused on the persistence of these institutions, or in the case of Richards and Hanlon, on their ineffectiveness, but not how these institutions evolved. During the war, 63 paramount chiefs died and thus elections were held in 2002 to fill these vacancies (Hanlon, 2005). Furthermore, in the case of a significant event such as a war, there are some institutional changes, and subsequently, changes in institutional quality (Bellows and Miguel, 2009; Voors and Bulte, 2014). Many post-war elected chiefs are from a contemporary generation and may have a more modern outlook. Today, this institution persists and retains popular support, according to the surveys presented in chapter one. There is no evidence that this institution has remained archaic, as all institutions are dynamic and change along with contemporary society. However, after the war, the government looked to the 1950s for a model of decentralization and the chieftaincy, instead of reforming the local government system for modern governance (Fanthorpe, Lavali, and Sesay, 2011). On the other hand, donors did not want to invest in a decentralization plan that has a strong chieftaincy institution (Fanthorpe, Lavali, and Sesay, 2011).

Acemoglu, Reed, and Robinson (2014)'s case study finds that political competition (i.e. an election) functions as a market competition to promote efficiency, and areas with low competition result in lower development outcomes. However, support and bonding

between citizens and chiefs may have to do with social capital, where fewer ruling families may have higher social capital. The authors argue that patrimonialism is a form of social capital, which encourages support for the chieftaincy institution but does not bring development. Rather, it locks villagers in a dependent relationship with their chiefs.⁵⁸

However, Bulte, Richards, and Voors (2018) critique Acemoglu, Reed, and Robinson (2014)'s assumption that chiefs are rational choice profit maximizers with political competition as the only factor to constrain their power. The authors concede there is some support for the hypothesis that chiefs who face greater political competition invest more in education and public health: public goods are positively correlated with multiple families. However, there could also be other factors that affect service delivery, as the number of ruling families was determined during the colonial era.

Also, scholars who thought that the paramount chiefs were responsible for the conflict (grievance-based reasons described in chapter one), or those who argue the rebels wanted access to diamonds or other natural resources (greed-based), an econometric analysis revealed that neither factors could readily explain the cause of the conflict (Bulte, Richards, and Voors, 2018). Harris (2013) argues that there were several factors of the neo-patrimonial state which left people with grievances and a need to exploit the social, political, and economic opportunities that come with war.

Thus, while social capital is an important concept to understand power and governance, Acemoglu, Reed, and Robinson (2014)'s interpretation of paramount chiefs being tied to the land and therefore locking in their constituents, may actually disempower rural villagers and stereotype them as unsophisticated citizens. Baldwin (2015) argues how rural citizens are sophisticated decision makers, whether it is in voting (instead of stereotyping chiefs as vote brokers) or resisting a chief.

2.4.6 The Debate on Governance and Chiefs

We cannot generalize that every chief governs fairly or effectively, as some chiefs are corrupt or may have despotic tendencies (Mamdani, 1996). Additionally, Acemoglu, Reed, and Robinson (2014), Beekman, Bulte, and Nillesen (2013; 2014) Hanlon (2005), Jackson

⁵⁸ Tangri (1980) also argues that colonial and postcolonial structures made the chieftaincy a wealth-maximizing office. However, most of that wealth is redistributed through patrimonial networks, and thus, it is only in a few chiefdoms (i.e. those with mining licenses) where the spoils are of a considerable amount. The chiefs are expected to be a paternal figure and dispense assistance, but their salaries do not permit them to live up to these social expectations.

(2005; 2006; 2011), Peters and Richards (1998), and Richards (2005) say that traditional leaders tend to be corrupt, and in the earlier debate, were partly responsible for the civil war in the Mano River region. However, some argue that the chiefdom should be dissolved in order for these societies to develop peacefully and democratically (Hanlon, 2005; Jackson, 2005; Jackson, 2006;⁵⁹ Richards, 2005), while others argue that they play an important social and customary role, and not to mention, have popular legitimacy (Adjei, Busia, and Bob-Milliar, 2017; Fanthorpe, 1998; Fanthorpe, 2001; Fanthorpe, 2006; Logan, 2013; Sesay, 2019; Ubink, 2008). However, for this thesis, this is binary and abstract, because the chiefdoms still exist many years after this on-going debate and we are interested in how they govern and this link to institutional quality. Moreover, the trend in the region is to integrate TLIs into state institutional structures, codifying and legitimizing their authority.

2.4.6.1 Problems with the Binary Debate

The literature has a largely theoretical and abstract debate of removing traditional authorities for ‘better governance and development’ or has argued that they are relevant for cultural and religious significance and therefore still have a role to play because of this. However, in many countries, traditional authorities are still in power and are participating in governance reforms or democratic reforms at the state and local levels (Baker, 2007; Baldwin, 2015; Casey, Glennerster, and Miguel, 2012; Dia, 1996; Neuffer, 2000; Tokpa and Yengbeh Jr., 2012; UNDEF, 2014). Therefore, it is not clear how the decades-old debate on removing tribal authorities have had an impact on today’s societies.

Furthermore, some of the literature that has been cited in favor of this, the authors have evolved their arguments. For example, Mamdani (1996) has been referenced in much of this literature for generally referring to chiefs as despotic. However, his discussion was largely on the manipulation of traditional authorities during the colonial era and how their powers were consolidated and made more authoritarian or how new authorities were created by colonial administrators. His broader thesis is that colonialism defined ‘customary law’ and ‘ethnic identity’ in a way that did not exist pre-colonialism (Mamdani, 2001). Consequently, chiefs are a symptom of a wider problem in SSA, a kind of identity politics

⁵⁹ Jackson (2005; 2006) discuss reforming the chieftaincy. Specifically, to depoliticize it and have chiefs act as “opinion formers and mobilizers” (Jackson, 2006, p. 108), which seems to contradict depoliticizing them. However, Jackson (2005; 2006) is critical of the internationally-led reforms in Sierra Leone but he supports external pressure on the Sierra Leone government to make reforms.

that is building nationalism and grants those as 'indigenous' with extra rights called 'customary rights,' that nonindigenous people do not have (Mamdani 2001; Mamdani, 2019). This is using Rwanda and its history between the Hutu and Tutsi ethnic groups⁶⁰ or in Uganda regarding the expulsions of Asians under President Idi Amin, as Asians were not seen as indigenous (Mamdani, 2001). Thus, while we discussed identity politics in Liberia and Sierra Leone in chapter one, the mainstream belief is that this was not equitable to genocide like in Rwanda.⁶¹

Richards (2005) and Peters and Richards (1998) have also been referenced for arguing that paramount chiefs in Sierra Leone are authoritarian and possibly a hindrance to post-conflict recovery. However, this could be contextualized into the specific debate of state-building in Sierra Leone, as later works from the main author, Paul Richards, do not criticize the governance of chiefs (Bulte et al., 2012; Bulte et al., 2013) and then support the role of the TLIs in governing the Ebola Virus Disease (EVD) outbreak and other matters (Bulte, Richards, and Voors, 2018; Richards, 2016).

In addition, Jackson (2005; 2006) argue that decentralization and state-building policies in Sierra Leone were reinstating these institutions that have poor governance. Consequently, this could lead to a return to violence, since former combatants have few prospects and access to patrimonial networks. However, in later research, Jackson (2011) on discussing legal pluralism, argues for reforming the chieftaincy by empowering the marginalized within local power structures. He still supports externally-led changes and cites a justice program led by the United Kingdom Department for International Development (DFID) as an example of this. This program may be a more productive way of engaging with chiefs, as the success of local initiatives is directly tied to them (Albrecht, 2010).

The arguments that support the role of chiefs have relied on cultural and religious positions to explain why they will always be needed despite how the state develops (Adjei, Busia, and Bob-Milliar, 2017; Fanthorpe, 1998; Fanthorpe 2001; Fanthorpe, 2006; Logan, 2013; Sesay, 2019; Ubink, 2008). The thesis does not disagree with the premise of this argument, although cultural and religious authority varies from state to state and within states. Nonetheless, rooting the legitimacy and authority of the chiefs in cultural and

⁶⁰ The Rwandan civil conflict started in 1990 and became known for the Rwandan genocide, with mass slaughter against the Tutsi people. See Mamdani (2019) for further reading.

⁶¹ See section 1.4.1 in chapter one, discussing how Bellows and Miguel (2009) and Harris (2012) do not believe ethnic tension was the cause of the war, but later, did help to create factions.

religious foundations is the beginning of understanding their authority and role in the community and not the entire picture.

The literature has largely confined paramount chiefs as having authority over customary law (Adjei, Busia, and Bob-Milliar, 2017; Bulte et al., 2013; Castillejo, 2009; Fanthorpe, 2001; Fanthorpe, 2006; Khan and Mehmood, 2016; Mamdani, 2001; Richards, 2005; Sawyer, 2008; Seidler, 2014; Severeid, 1993; Ubink, 2008). However, in many states, their powers and jurisdiction are more broadly defined, and they do act on behalf of state institutions, for example, to collect taxes (Chieftaincy Act, 2009; Local Government Act, 2015; Local Government Act of 2018, 2018; The Local Government Act, 2004). Or, in another example, Liberia recently passed a legislative act through the senate to formalize bylaws as legal regulations by the chiefs and district authorities (Local Government Act of 2018, 2018). This also means that mechanisms of enforcement could involve state institutions (police and judiciary) and not just TLIs. This would support a polycentric approach to governing, where state institutions support local institutions' agendas (Mansbridge, 2014; Oström, 1990).

2.4.6.2 A Third Approach

In this cohort, authors are aware that there is a broader discussion on whether traditional leaders should stay in power or be dissolved. However, their mostly evidence-based research focuses on how these leaders currently govern and the measurable impact or outcomes. Acemoglu, Reed, and Robinson (2014), Beekman, Bulte, and Nillesen (2013; 2014), and Pande and Udry (2005) examine the institutional quality with an interest in economic outcomes. The first three are concerned with how corruption can impact local investment and found that areas with corrupt chiefs or chiefs with less political competition (from other ruling families) had worse investment and development outcomes.

Pande and Udry (2005) say that the main body of literature on institutional quality, change, and economic growth mainly use indicators that are faced by businesses and individuals in the formal and urban sectors. This literature also takes a broad country-level analysis, which can overlook various institutions at the micro-level. The authors examine rural institutions for institutional quality, acknowledging that mechanisms for contract enforcement differ from a business. However, this still uses low transaction costs as a determinant of institutional quality. Thus, for many agrarian societies, land tenure (property

rights)⁶² is key for economic opportunities. In Ghana, it is the responsibility of the chief to ensure that land is available for the subjects. A chief can sell land to outsiders and this has happened, especially in urban areas (Pande and Udry, 2005). However, the authors say that this is rare and when attempts to sell have happened, it resulted in the overthrow of a chief.

In Ghana, the land is transferred through matrilineal inheritance and the chief is incentivized to make sure that poor subjects have access for farming. The chief will set conditions to allocate this land such as not allowing it to fallow.⁶³ This will weed out rich people in the area as cultivating land is very labor-intensive and income from nonfarming is much higher. Therefore, only poorer citizens will accept the land under these conditions and the chief can stay in power. Land reform is needed to guarantee long-term security, but for now, more conditions are placed on the land to mitigate population pressures. According to Pande and Udry (2005), this micro-level examination helps us understand the institutional changes that may affect economic growth.

There are some who suggest that TLIs can be reformed or part of better governance and local development efforts (Baker, 2007; Baldwin, 2015; Casey, Glennerster, and Miguel, 2012; Castillejo, 2009; Dia, 1996; Jackson, 2011; Sesay, 2019; Tokpa and Yengbeh Jr., 2012; UNDEF, 2014; Unsworth, 2010). However, the approaches and focus vary. For example, Baker (2007), Jackson (2011), and Sesay (2019) write on the dual judicial system, a formal one by the state and the customary courts led by the chiefs. Community-based policing methods have provided security in post-conflict states, where order, conflict, and behaviors are monitored by the community. This tends to be more important in states that have a negative perception of state policing because of the role of the state during the civil conflict (Baker, 2007). Castillejo (2009) and Jackson (2011) argue that customary courts in Sierra Leone can abuse their power, passing arbitrary bylaws that citizens may be unaware of, or punitive measures that violate human rights. However, Sesay (2019) says that customary courts and bylaws may have greater legitimacy at the community level. Thus, post-conflict reforms should take into account social practices governed by TLIs that are helpful for cohesion and conflict mediation and differentiate between the harmful ones.

⁶² Land is treated as a communal good in most SSA countries and not private property rights, but Pande and Udry (2005) still count it as property rights as the individual can economically gain from it.

⁶³ In agriculture, this refers to farmland that is left for a long period without being sown in order to restore fertility. Sometimes, fallowing is done purposely to avoid surplus production.

Baldwin (2015), Tokpa and Yengbeh Jr. (2012), UNDEF (2014), Unsworth (2010) broadly discuss how TLIs can be used in local development efforts. Baldwin (2015) gives an example of how chiefs have worked with elected officials to organize communal labor to make mud bricks for a school. The elected official managed to secure funding to build a school but needed bricks, hence, he had to work with the local chiefs to organize the community as the response would not have been the same if he organized it himself. However, Unsworth (2010) says that the effectiveness of these local leaders varies either by working well with state institutions or sometimes undermining their efforts. She believes that this could partly be explained by colonial origins, whether TLIs were ruled directly or indirectly by European powers.

However, politics could be another explanation. Logan (2013) and Ubink (2008) say that although traditional leaders still have popular legitimacy, how would integration affect democracies in SSA? Indeed, this literature suggests that TLIs may be beneficial to democracies, however, this is only in the form of delivering public goods. As a political theory, liberal democracy also includes human rights issues, such as gender equality, freedom of speech, freedom of assembly, a trial by peers, and other notions of individualism, liberty, and justice (Carothers, 2002; Harris, 2012; Hellsten and Larbi, 2006; Omotola, 2010; Mustapha, 2016; North et al., 2015). On the one hand, one must consider the norms, principles, and ethics that are valued in individual societies. As discussed in section 2.4.3 regarding customary law, these rights are exercised with communitarian values. However, TLIs do not always deliver or promote these, and these liberal democratic values are weak in state institutions too.

Baldwin (2015), Bulte, Richards, and Voors (2018), and Fanthorpe (2006) say that chiefs are accountable to their constituency through nonelectoral means. This would mean that there are ways of good governance outside the World Bank (2002)'s limited electoral strategies. Bulte, Richards, and Voors (2018) argue that West African chiefs are brokers of multiple institutional orderings, such as government, justice, village, and development. They argue that a chief can only carry out his or her duty with the respect and confidence of electors from landowning families. And those that tend to be autocratic will be met with stubborn resistance. Baldwin (2015) says that historically, people who did not like their leader could vote with their feet. A depleted population would mean less tributes (or taxes) paid to the chief; and this would economically and socially hurt his or her standing.

Nowadays, “bad chiefs would be the subject of gossip and ridicule, and subjects would refuse to provide customary tribute or to work on their farms.” (Baldwin, 2015, p. 26). Indeed, Fanthorpe (2006) discusses two unpopular chiefs in Sierra Leone, who won their elections because of patronage from the All Peoples Congress party (APC), and not through the normal electoral process, and as a result, lacked legitimacy. One so lacked the support of his constituency that he could not even organize a community meeting, and another had to live outside his chiefdom for many years. Thus, despite weak state institutions, there are checks and balances on the power of traditional leaders. This is congruent with what North (1991; 2003) says about cooperation being maintained by reputation, “the reputation may be political, moral, spiritual, or even idiosyncratic, or, often enough, all four at once,” (North, 1991, p. 104). Even though many countries are developing bigger markets, reputation in rural communities may still crucial for cooperation.

It is in this debate on governance and institutional quality of TLIs where this thesis fits. It demonstrates how TLIs have the institutional quality to affect development from Pande and Udry (2005) and Unsworth (2010), but also, how good governance can be seen differently from liberal policies as discussed in Baldwin (2015), Bulte, Richards, and Voors (2018), and Fanthorpe (2006). The next section discusses how institutional quality can be extended for social outcomes.

2.5 Extending Institutional Quality

Hanlon (2012) argues that ‘good governance’ defined by the International Finance Institutions (IFIs) is supply-side economic management and increased inequality, while social welfare policies that are considered ‘poor governance’ (e.g. cash-transfers) are demand-led and equity-based development solutions. Thus, locally-derived solutions, such as in Brazil or China, to correct demand-side barriers are not seen as good governance in the current development models.

If we understand (good or high) institutional quality as low transaction costs, enforcement, and protection of property rights for economic growth, then we see why the debate has mainly focused on state institutions and the mixed performance of development aid resources. What is missing is the discussion of institutional quality as low social costs to protect social development and welfare. If the qualities for state institutions for economic

growth are preferred, then it stands reason to ask, what are the qualities needed for social development and humanitarian welfare and extending this theory to explain market failures and corrections during the Ebola epidemic.

2.5.1 Market Failures and Social Outcomes

The thesis holds that there are two market failures that TLIs can correct. In the literature highlighted below in sections 2.6 and 2.7, in a public health emergency, there is sometimes a lack of knowledge about specialized equipment or disinfectants to make activities safer and prevent the spread of an infectious disease. When there is a degree of misinformation or lack of knowledge that affect consumers' choices, this is called an 'information failure' in the market (Jha and Chaloupka, 2000). When there is an information failure, consumers (i.e citizens) may not demand products such as chlorine or new boreholes for Cholera prevention. Lack of knowledge of early symptoms or personal protective equipment (PPE) to prevent infection can also lead to under-consumption, even if these resources are available for free by donors or humanitarians. Citizens may not use them because they are unaware that such products are needed to act safely during an emergency. This concept expands on Jha and Chaloupka (2000)'s work on information and regulation of tobacco in low-income countries. They argue that there is an assumption that consumers are educated about risks and benefits on the goods or services they consume. In their study, they argue that consumers are not knowledgeable of tobacco risks or under appreciate the gravity of smoking on their health, to choose not to consume tobacco products. Therefore, government intervention via regulations and information is needed to lower the demand; thus, preserving the health and welfare of the population.

The second market failure is 'social cost.' According to Becker and Becker (1997), negative health behaviors such as tobacco smoking or alcohol consumption bear many costs that are not only absorbed by the consumer. When an individual chooses to consume these products, there is first a private cost that the individual bears. However, his or her actions can contribute to costs that other individuals bear, such as the potentially fatal consequences of driving while intoxicated (from alcohol consumption) or the costs of tobacco-related morbidity on health insurance programs. According to Reubi (2016), information failure and social costs can lead to economic inefficiencies that must be corrected through government intervention (regulations). In this paper, the regulations that

were passed to correct these market failures were sin taxes and the World Health Organization (WHO) 2003 Framework Convention on Tobacco Control (Reubi, 2016). The upcoming literature review of the 2014 Ebola epidemic discusses information failures that caused challenges for aid resources to perform. During this outbreak, some behaviors such as hiding sick people or performing unsafe undertaking and burials, not only had an individual cost, but also a social cost because these behaviors prolonged the disease spread (Carter et al., 2017; Dietz et al., 2015; Richards and Mokuwa, 2014). This affected communities and the economy, as production stopped. That is until TLIs intervened with regulations. Unlike the concept of ‘social benefits’ discussed above (Oström, 1990), the thesis takes a market approach to discuss the reduction of social costs. This is about reducing negative externalities and not necessarily gaining an economic opportunity.

For instance, Parker and Allen (2018) and Parker et al. (2019) discuss Mathiane village in Sierra Leone where ‘secret burials’ and home care of the sick took place, despite laws against this. According to their interviews, the people heard public health messages on the radio but did not feel that they could relate to them and did not trust that hospitals would safely care for their loved ones. On the surface, this seems that there was a distrust of health and state institutions and people ignored the information given by public health officials. However, Richards (2016) and Chandler et al. (2015) explain that much of the information channeled through state institutions was theoretically correct and conceivable but did not fit the local context. So, it is still misinformation for neoclassical analysis because the information given must fit the local context and culture. This is further reviewed in section 2.7.3 on the Ebola outbreak literature.

2.5.1.1 Institutional Quality for TLIs

Understanding institutional quality in this light, the theory is still the same, meaning there needs to be trust and enforcement of the rules under these institutions (North, 1990; North, 1991; North, 2003; Oström et al., 2001). Conteh (2013), Logan (2013), Sesay (2019), Tokpa and Yengbeh Jr. (2012), and Ubink (2008) say that mediation and judicial processes are still carried out under TLIs. Rulemaking, defined as bylaws, are laws in every legal and judicial sense that we understand lawmaking. These institutions also have the authority to impose fines and penalties for those who do not follow the rules (Chieftaincy Act, 2009;

Local Government Act, 2015; Local Government Act of 2018, 2018, 2018; The Local Government Act, 2004).

However, if we focus on broader issues of social outcomes and human security such as education and health, this too can bring economic growth (Aldis, 2008; Piccone, 2017; Werner and Sanders, 1997). In this perspective, these indicators are instrumental to economic growth, but institutional quality does not focus on market-led economic growth.⁶⁴

2.6 Public Health Emergencies

When it comes to emergency management, communities are referenced as ‘key resources’ but are often overlooked in proactive and reactive stages of emergency management (Murphy, 2007). While there is literature (Acemoglu, Reed, and Robinson, 2014; Casey, Glennerster, and Miguel, 2012; Fearon, Humphreys, and Weinstein 2009; Ubink, 2008) discussing TLIs and their governance, their voices and perspectives are not included.⁶⁵ Fewer published works (Baldwin, 2015; Pediti et al., 2017; Richards, 2016), interview or include the perspectives of these leaders. There could be many reasons, such as lack of access in the field or even lack of ability to conduct fieldwork in rural areas in low-income countries (Piccolino and Franklin, 2020). Scott (1992) argues there are two sets of transcripts regarding how those in power engage with marginalized communities. First, a public discourse that is overwhelmingly used in academia that portrays a sense of harmony and cohesion between those in power and the powerless. This concept is demonstrated below, where we discuss community engagement strategies in public health emergencies. The dominant narrative is that humanitarian agencies went into communities and ‘organized’ them or trained a select group of ‘community stakeholders.’ This transcript has disempowered and rendered TLIs silent in the literature. Second, there is a hidden transcript that is used within groups (Scott, 1992). Not many scholars have access to observe and converse within local groups to analyze the latter.

⁶⁴ To further emphasize this importance of social outcomes; production stopped, and the economy shrank during the Ebola outbreak (World Bank, 2014). The thesis only examines EVD deaths as a social cost, but other health services stopped too. Huber, Finelli, and Stevens (2018) estimate a million fewer children were vaccinated against measles, which may lead up to 16,000 more measles-related deaths in subsequent years. So, resolving the disease outbreak led to a return of economic activities in the short-term and prevented further negative long-term impacts.

⁶⁵ Secret societies are hardly mentioned in this literature except in Acemoglu, Reed, and Robinson (2014), Harris (2013), Jackson (2006; 2011), and Richards (2016).

Scott (1992) defines this hidden transcript as the language for subordinated groups, meaning those who are powerless. However as explained above, TLIs have been very influential in local politics for centuries despite colonialism, post-independence, and even post-conflict reforms to manipulate or eradicate them. Therefore, in their local communities, they are not powerless, but their knowledge and voices have not been well integrated into the public transcript of the 2014 Ebola epidemic. Scott (1992)'s analysis is useful for us to think about how emergency interventions have been published; depicting international and state institutions leading the response and community stakeholders rendered as passive apparatuses. The 2014 Ebola epidemic has brought more research regarding community-level organizing, which will be discussed section 2.7, revealing a hidden transcript that contradicts the public one.

2.6.1 Definition of Public Health Emergency

To understand how aid performance is related to local governance and participation of community stakeholders, we must first define the event of the 2014 Ebola epidemic and what the current research says about engaging local communities during an outbreak. The Ebola virus is known as a Viral Hemorrhagic Fever (VHF) in which we currently know five subtypes (Marí Saéz et al., 2015). EVD is highly infectious and has mostly occurred in remote areas with fatality rates up 90% (Pourrut et al., 2005); thus, an outbreak of this virus has usually warranted some level of organized assistance and response. However, in 2014, the outbreak had spread to populous urban areas in Guinea, Liberia, and Sierra Leone affecting thousands of people. Given the massive and unseen before prevalence, the WHO declared this a Public Health Emergency of International Concern (PHEIC) on August 8, 2014 (World Health Organization, 2014c).

'Public health emergency,' is defined for this thesis as an outbreak of an infectious disease that poses a threat to the security and stability of the state and requires an international response.⁶⁶ However, the literature is not limited to events where PHEIC was declared. Before the 2005 International Health Regulations (IHRs) came into effect in 2007, if a nation had a public health emergency, it invited the WHO, technical expertise, and coordinated aid resources (Kamradt-Scott, 2015).

⁶⁶ Full definition was discussed in the introduction on page xvi.

At this level of literature, we come to the first conceptual understanding of local participation and aid effectiveness in this context. The aid resources are humanitarian assistance that is usually mobilized quickly and for the short-term to stabilize a situation during an emergency. This distinction of aid was discussed in chapter one.⁶⁷

2.6.2 The Public Transcript on Emergency Interventions

In a case study published by DFID and Oxfam on the October 2010 Cholera outbreak in Haiti, this public health emergency came as a direct result of a massive earthquake that displaced over three million people ten months beforehand in January (U.K. Department for International Development, 2011). According to the report, DFID and Oxfam along with the Haitian Ministry of Health designed a health education strategy on water and sanitation management. They trained community health workers to go door-to-door to deliver key messages on better hygiene practices to reduce the spread of Cholera (U.K. Department for International Development, 2011). This practice is called community sensitization and we see it deployed as a strategy for public health. It is limited around health education and health promotion to change behavior and does not take local knowledge into account.

Gabon experienced three waves of EVD outbreaks between 1994 and 1997, with the first wave having confirmation of patients co-infected with Yellow Fever (Georges et al., 1999). A team from the Centre International de Recherches Médicales de Franceville assisted in the response, however, their perspectives on the community and demand-side barriers were very limited in this paper. “It is important to note that during this investigation, we continually faced many difficulties (e.g., logistics problems and cultural and political constraints) in the collection of data and management...” (Georges et al., 1999, p. S65). The authors discuss a technical and biomedical approach to identify and prevent the spread of EVD and the need for better diagnostic equipment to rapidly identify any VHF. They conclude that from a public health point of view the best way to prevent an outbreak of this type is simple barrier nursing methods.⁶⁸

⁶⁷ See the first section on aid in chapter one starting on page 3.

⁶⁸ Barrier nursing method refers to infectious disease control. There are different methods depending on how infectious a patient may be. ‘Simple’ methods may refer to basic PPE such as gloves and masks, while ‘strict or rigid’ may refer to more protective barriers like a full bodysuit or isolation of patients. See BMJ (1966) and Landers et al. (2010) for further reading. In chapter four, some informants also refer to this as the Infection Prevention Control (IPC) training they undertook during the 2014 EVD outbreak.

In Angola, a 2007 Marburg Virus outbreak (another VHF similar to Ebola) had humanitarian agency, Médecins Sans Frontières (MSF) responding to the crisis with the Angolan Ministry of Health and the WHO (Roddy et al., 2007). They say there is a typical biomedical paradigm to address infectious VHFs, such as the use of specialized equipment, epidemiological surveillance (also known as contact tracing),⁶⁹ and biomedical information to help contain the spread of the disease. However, despite the agency bringing the best technical expertise and equipment, the authors acknowledge that their aid would be less effective without community support. Therefore, the international team changed its community engagement strategy to make social practices, such as burial rituals and home care safer; this is to reduce stigma and the spread of the Marburg virus. Although cultural practices are considered in this example, community members are viewed as passive recipients of aid intervention using ‘cultural interpreters,’ and not engaged participation. In addition, they learned that biomedical education needed to de-emphasize a disease’s fatality and place more emphasis on prevention and early treatment. Indicating an information failure during the outbreak.

In 2000, there was an EVD outbreak in the rural village of Rwot-Obillo, Uganda that spread to neighboring districts. According to Okware et al. (2002), the WHO and a coordinated response team worked with the Ministry of Health to stop the outbreak. A biomedical paradigm is explained of infection control, PPE, along with health education and community engagement efforts. However, just like the preceding examples, local health workers and volunteers are trained to sensitize the community and this information was disseminated daily and managed through the centralized national taskforce with the government. According to the authors, government commitment and decentralized mobilization efforts to educate and surveil the communities for potential sick persons for early treatment (contact tracing) was an effective response.

In addition, there are other disease outbreak reports, which discuss interventions from the supply-side of the market, such as augmenting nongovernmental organization (NGO) support and clinical resources. However, they do not address how the donors or humanitarians fixed social or cultural challenges (demand-side barriers) or how specific

⁶⁹ Contact tracing is from the WHO’s resource on managing EVD outbreaks. It is the identification and follow-up with persons who may have encountered an EVD patient. These persons are monitored for at least 21 days for any symptoms. See Centers for Disease Control and Prevention (2016b) and World Health Organization (2015e).

community leaders were able to lead in this capacity (Allaranga et al., 2010; Centers for Disease Control and Prevention, 2007; Enserink, 2005; Lamunu et al., 2004; Msyamboza et al., 2014; Muñoz, 2017; Onyango et al., 2007; World Health Organization, 2007; World Health Organization, 2009). Some broadly discuss social and cultural challenges (Enserink, 2005; Msyamboza et al., 2014). Some focus on biomedical strategies solely, such as clinical resources or delivering public health information (Centers for Disease Control and Prevention, 2007; Muñoz, 2017; World Health Organization, 2007; World Health Organization, 2009).

Allaranga et al. (2010) is a systematic review of several VHF outbreaks and it suggests that these and future outbreaks are best addressed through integration and coordination between local health officials and wildlife officials, as VHFs are a class of zoonotic diseases.⁷⁰ Lamunu et al. (2004) discuss the 2000 EVD outbreak in Uganda too, however, the experiences with WHO officials and community support differ from Okware et al. (2002). The outbreak response was prompt (48 hours after detection) and community stakeholders were mobilized and trained soon afterward. However, this still did not change the overall EVD death rates compared to previous outbreaks, because most exposures and deaths happened before the virus was detected and confirmed, and this took about six weeks. Thus, it seems the response from international actors was not effective in reducing deaths (social costs).

In the recent EVD outbreaks in the Democratic Republic of Congo, Médecins Sans Frontières (2018a; 2018b; 2019) has written project updates about the agency's work in the field to contain the disease outbreak. The topics on trust and community relations were reviewed, and the predominant narrative is that trust was built through the supply of clinical resources such as sanitation and waste management, "honest" information on disease, and free medical screenings, not just for Ebola. Families are also able to visit EVD patients too, to help dispel any myths or rumors. So far, the literature has focused on biomedical resources as the solution, and moreover, highlight the use of a new vaccine in this recent outbreak (Cohen, 2018; Ilunga Kalenga et al., 2019; Moran, 2018; Nkengasong and Onyebujoh, 2018; World Health Organization, 2018e). All sources note that responders conducted some kind of community engagement strategy but do not give further details.

⁷⁰ A zoonotic disease can be transmitted between animals and humans (Marí Saéz et al., 2015; Pourrut et al., 2005).

In the above examples, the interventions during a public health emergency mainly included sensitization efforts to, first, give out the right information in a market where there is misinformation or none. In the example of Haiti, community members were not drinking clean water and did not know how to properly disinfect their local water supply after the earthquake damaged the infrastructure. In Angola, family members were taught safer practices to care for sick relatives to prevent transmission of the Marburg virus. And, public health education about EVD symptoms helped to trace sick persons for case management in Uganda. In these cases, community engagement strategies are integrated into a biomedical paradigm for emergency intervention. Specifically, the strategy is to train or give biomedical knowledge to bring about a specific behavioral change, such as bringing a sick relative into the health facility or consuming goods that are available for health and hygiene, such as chlorine tablets or oral rehydration solution packets. However, community engagement strategies vary as some efforts do not include traditional knowledge from the local communities, and sometimes their voices are not integrated beyond training for behavior and consumption changes. Therefore, these are top-down interventions, which contradicts the 1978 declaration of the *Almá Atá* Conference on wider community engagement (World Health Organization, 1978a).

Second, in these examples, engagement with the community was limited to health education and promotion to avert 'risky' behavior for disease transmission (e.g. drinking unclean water or caring for a highly infectious loved one at home). 'Risky behavior' in this sense includes cultural rites and customs that may not have been as risky at times without an infectious disease outbreak (e.g. funeral rites).⁷¹ The strategies of these agencies are designed to promote the supply of aid resources (e.g. latrines, chlorine, or treatment units) via health sensitization methods. This is a strategy deployed through an interagency communication toolkit designed by the WHO, the United Nations Children's Fund, and the Food and Agriculture Organization (World Health Organization, 2012a). This toolkit helps identify community perceptions and behaviors that may have a negative or positive impact on disease prevalence. It uses a situational market analysis and based on any underlying market failures, aid resources are deployed through a type of community engagement

⁷¹ Some VHF's such as Marburg or EVD are highly infectious on a corpse that died from the disease (Preston, 2012). Therefore, during an outbreak, some response measures included mass cremation or other strategies to avoid common funerals (Enserink, 2005; Hewlett and Hewlett, 2008; Richards, 2016; Roddy et al., 2007).

campaign. Unsworth (2009) says that aid resources tend to be viewed as apolitical and supply-driven approaches (e.g. building schools, roads, or bringing equipment); however, while supply-side factors may be apolitical,⁷² the demand-side barriers are very much cultural and political, and that includes how externally derived resources perform or become efficient.

Third, the role of TLIs is not defined or discussed in the case studies, except as being consulted with or recruited for training (Centers for Disease Control and Prevention, 2007; Enserink, 2005; Lamunu et al., 2004). When NGOs and multilateral agencies respond, they usually do so through state institutions such as the ministries of health mentioned above. The WHO cannot enter and provide aid unless it is invited through state institutional channels, or in extreme cases it declares PHEIC. There have been cases where experts at the WHO know of an active outbreak through the Global Outbreak Alert and Response Network (GOARN), a medium where NGOs and partners in various countries report unusual occurrences (Kamradt-Scott, 2015). However, without an official invitation, the WHO cannot intervene unless there is a significant security risk to the region, hence why the IHRs were designed in 2005 (Kamradt-Scott, 2015). The literature broadly says community stakeholders are helpful for cooperation and behavior changes, but it is not always specified who consist of the community stakeholders and TLIs are not examined for governing the outbreak. The public transcript (Scott, 1992) of how disease outbreaks have been resolved, is that agencies or organizations intervened and simultaneously corrected supply and demand barriers through their strategies. Or demand-side barriers are mentioned, but not explored, implying these were not significant to preventing or eradicating the disease (Allaranga et al., 2010; Georges et al., 1999).

For this reason, the thesis will add a missing branch to this operational level of the literature. These community engagement strategies do not fully explain how humanitarians and donors are resourceful during a public health emergency. Institutions at the community level define behaviors and norms of the people, and a top-down situational market analysis cannot implement behavior change alone. Nor will giving the right message, as we will explore what happened during the 2014 Ebola epidemic.

⁷² The notion of aid being apolitical is challenged by many sources discussed in chapter one in section 1.2 on the conditionalities and impact on health. These sources claim that aid has followed a neoliberal ideology (Chorev, 2013; Kickbusch, 2005; Mathews, 2007; Navarro, 2007; Tirman, 2005).

The literature reviewed in this section includes reports and papers from NGOs and government agencies. The positive aspect is that these are first-hand accounts from the field with access to local stakeholders that many scholars from the United States or Europe may not have. Knowledge and deep insight from these communities are invaluable contributions to the overall academic debate. Some of these sources cited are not writing in a critical light or conducting research for scholarly fashion; they are writing for a different audience. The journalistic styling of the reports, emphasis on the NGO's positive impacts, and appeals for more resources suggest an audience of donors. This may explain why the NGO is often highlighted as the lead actor, while community stakeholders are relegated into supporting roles. Also, government agencies (like DFID) have a similar style suggesting an audience of taxpayers where the agency's humanitarianism can be used for political self-promotion. Nonetheless, the use of these sources is crucial to understanding how strategies evolved and its reflection on aid effectiveness.

In addition, there are many charities and aid organizations that have provided services for decades but do not publish their work for the wider audience. Thus, a veteran aid or humanitarian worker may have intrinsic knowledge on community engagement and demand-side barriers that is not available in the academic or gray literature. So, there can be another hidden transcript regarding how humanitarian agencies and charities operated and engaged with the community.

The biomedical strategy was not so effective during the 2014 Ebola epidemic (Perry and Sayndee, 2017; Richards, 2016). There are epidemiological reasons for why this outbreak was different, however, epidemiology does not fully capture what changed the disease spread. In the case studies above of Haiti, Angola, Gabon, the Democratic Republic of Congo, and Uganda, the public transcript (Scott, 1992) says that top-down community engagement and clinical resources helped the response, but once local communities 'cooperated.' This may imply that these strategies were just not effective in the recent West African epidemic for lack of cooperation, knowledge, and/or cultural rituals that seem 'odd' to international responders.

2.6.3 An Emerging Transcript

In between Scott (1992)'s concept of a hidden transcript and public transcript, some sources are critical of the dominant narrative. However, do not completely give the

perspectives of how community and traditional leaders governed an outbreak. For example, Hewlett and Hewlett (2008) are medical Anthropologists who travel to outbreak epicenters to research cultural norms and disease outbreaks. They explain that demand-side barriers for international humanitarians and local government officials happen often. They position the work of medical anthropologists as an important broker between Western biomedical interventions and culturally sensitive health education. As an example of the importance of their work, they explain how international teams were evacuated twice during the 2002 EVD outbreak in Gabon because medical anthropologists were not sent in first to initiate community engagement and conduct cultural liaison. Thus, an 'emerging' category is created to analyze this literature.

Leach and Hewlett (2010) discuss "outbreak narratives" that tend to be associated with VHF, with a focus on EVD and Lassa Fever. The first is a "global threat" narrative where these diseases are depicted as a deadly threat in a highly mobilized world, specifically to Western countries as this is where this narrative dominates. Additionally, this narrative presents Africans with "bizarre cultural practices" such as eating monkeys and tribal rituals. This narrative also has a policy implication, as the role of doctors, nurses, scientists, and government officials are emphasized in containing the disease. "Publics are rarely shown or discussed in these narratives and when they are, they are often represented as either as ignorant and backward (especially in African settings) or as panicked and ineducable (especially in European and American ones)" (Leach and Hewlett, 2010, p. 51).

Another narrative discusses VHF as long-term diseases that are endemic to African societies, rather than then "short-term or sporadic" outbreaks. This looks at structural issues in the community that make societies vulnerable to a VHF. For example, Lassa fever is transmitted by certain rats that feed on rice, and hence, people who live or store rice in poor structures may be vulnerable. Underequipped health centers can hinder VHF containment along with the pressures of urbanization and population migration. According to Leach and Hewlett (2010) in this narrative, one cannot separate the issues of poverty from equitable health in addressing VHF.

Hewlett and Hewlett (2008) and Hewlett and Amola (2003) discuss how communities have managed EVD outbreaks in some areas like Uganda or the Democratic Republic of Congo, using the local term, *gemo*. These communities had developed protocols to care for EVD patients and bury them safely since the pre-colonial days, according to their interviews.

They also describe spiritual rituals to chase away spirits. However, this is not to say that there is a lack (or rejection) of biomedical knowledge as sometimes caregivers would purchase antibiotics too, to help treat symptoms. Rather, spiritual rituals are about social cohesion and urging people to remain calm during an outbreak. People would also refrain from close contact during outbreaks, such as dancing and sex. Protective sequestrations⁷³ are recorded in these rural communities when an outbreak is suspected in the village:

The community decides to close the village, and nobody enters or leaves. The protocols discourage movement of any kind and place barriers on roads and trails leading into the village. The chief and his appointees monitor who comes into or goes out of the village. Close (1995) describes several instances during the original Ebola outbreak in Yambuku where nuns and priests traveling along the roads encountered barriers outside of villages where they had to plead with the chief to let them drive through the village (Hewlett and Hewlett, 2008, p. 136)

Hewlett and Amola (2003) discuss other local emergency management protocols when *gemo* is suspected, such as a short isolation period once EVD survivors stop showing symptoms. Subsequently, these survivors are tasked to care for the sick and bury the dead outside the village. Back then, it was not known in the medical community how long immunity lasts. Only recently did a study show that EVD survivors may be immuned from the disease for decades (Rimoin et al., 2018).

2.7 Transcripts from the 2014 Ebola Epidemic

This section discusses the local governance challenges of the 2014 West African Ebola epidemic. The introductory chapter gave a brief timeline of key events and the path of EVD. Then, the first chapter gave an introduction of the epidemic, from a macro-level perspective of the response. That chapter analyzes the challenges on the supply-side of the market. In this section, the literature debates failures and successes in the community engagement strategies, hence, focusing on the demand-side barriers.

However, as mentioned in the introduction, community engagement is used as an umbrella term for different emergency interventions that agencies and donors employ to change behaviors.⁷⁴ The literature conceptualizes community sensitization, community participation, community engagement, social mobilization...etc., differently. However, it is

⁷³ 'Protective sequestration' is a term used in public health to describe when healthy people isolate themselves to prevent illness. 'Quarantine' is defined as isolating people who were exposed to a disease (European Centre for Disease Prevention and Control, 2009). The term protective sequestration implies that this is voluntary, but the literature does not always make a distinction. Moreover, not all informants interviewed for this research specified between the social isolation policies. Therefore, since these policies were enforced by local and domestic authorities, the thesis uses 'restrict movement' or 'isolation' throughout to refer to any policy that banned movement and personal contact.

⁷⁴ See page xv for terms on community engagement.

not within the scope of the thesis to define these terminologies or argue which strategy works best. Each donor and humanitarian organizations has its strategies and it is not governed or enforced by any single international agency, despite the passage of the 1978 Almá Atá Declaration to engage equitably with local communities and the Sphere Standards (Sphere Association, 2018; World Health Organization, 1978a). Therefore, because these actors have different understandings of community engagement, this led to different approaches and different understandings of what is possible in emergencies (Oosterhoff, Mokuwa, and Wilkinson, 2015). Nonetheless, the terminology may be conflicting and confusing if one source shares the same label with another source, but the agencies implement their respective strategies differently.

The literature also uses various terms to refer to external partners (donors, NGOs, humanitarians, responders...etc.). However, when discussing their strategies in a critical light, it is not always clear if they are referring to actors who came to West Africa just for the EVD outbreak or actors who had a presence in West Africa beforehand and aided in the response too. Donors and NGOs with a long-term presence in local communities may have had a different knowledge or relationship within these communities.

2.7.1 Structural Violence and Community Resistance

Chapter one discusses the debate on the 2014 Ebola epidemic framed as a failure of development policies, and to a lesser extent, a failure of international intervention. However, at the community level, we also see arguments of failures of integration due to colonial, political, and economic exploitation by the domestic political elite and the international community. The thesis does not argue against the historical and socioeconomic legacies of exploitation, but this critical analysis may remove agency from local actors. For example, Nunes (2016 p. 543) says the 2014 EVD outbreak centered on “neglect”. He describes how health issues emerge as something to be governed or ignored at the international level. Neglect is produced in the context of power-laden global relations and structure. By framing the epidemic as an exotic and racialized phenomenon, it was enveloped in a media and political spectacle, which resulted in short-term crisis management results while deep-seated neglect continued. However, at a macro perspective, it may seem that neglect continues by global and domestic decision makers, but it does not give agency to community-level leaders who did not neglect the immediate

or systemic problems in the healthcare system. Neglect is also a form of structural violence, as the remaining literature examines below.

Fairhead (2016), Leach (2015), and Wilkinson and Leach (2014) view the communities' resistance to the government and aid workers as a response to structural violence. This means an accumulation of decisions and reactions over time that led to inequalities in the economic, education, health, and social infrastructure of these communities. In this region, there is a history of structural violence by international and domestic actors. Wilkinson and Leach (2014) describe how post-conflict development in West Africa decimated healthcare systems, while promoted annexing land for mining and agricultural investment for private and usually foreign entrepreneurs. This has displaced many people and impacted their livelihoods. Additionally, these were largely through international donor policies encouraging foreign direct investment that has integrated national and local institutions, including the chiefdoms. Thus, donor and aid organizations are also partly responsible for implementing and sustaining structural violence in these communities (Fairhead, 2016; Leach, 2015; Wilkinson and Leach, 2014). Wilkinson and Fairhead (2017) discuss how communities in Sierra Leone were noncompliant by practicing social customs in secret such as burial rites, while in Guinea there was active resistance where communities would (sometimes violently) drive away aid workers who came to do contact tracing. EVD started in the remote forest regions in both countries, which have a history of economic and political marginalization, hence resistance is a response to structural violence.

Wilkinson et al. (2017) say that although international responders changed their approach at some point in the intervention to engage with communities and respect local customs, they may persist with unequal power structures within the societies. They argue there needs to be a reconsideration of the concept of 'community.' In the public health realm, communities tend to be reduced to geographical catchment areas of those at risk for a disease (Wilkinson et al., 2017). However, these are externally derived definitions and may not match how people perceive themselves to be a part of a community (Chambers, 1997; Wilkinson et al., 2017). They warn there can be a romanticized vision of people being socially bound to communities or community leaders being completely altruistic. Some

community engagement strategies⁷⁵ are one-size-fits all packages, which may not fit the community in question. Wilkinson et al. (2017) say that some public health interventions can reinforce or create social hierarchies that are resented.

For example, in Guinea, external partners identified local leaders such as village chiefs and district officials, but the community resented many of them. However, after three days of interviews with local people, a list of trusted community leaders was created, and this was completely different from those who were identified by external partners. However, Wilkinson et al. (2017) do not contextualize this article into their prior work of structural violence in Guinea, in which there was a lack of trust of state and some community institutions (Leach, 2015; Wilkinson and Leach, 2014). This can be problematic for policy recommendations where earlier they argued that there was a mistrust of state and district officials due to historical legacy, but now some traditional leaders too. NGOs depend on state institutions to gain access to remote villages and often work through them. Bypassing the state to work exclusively with community leaders may create a parallel or dual system to channel aid (essentially recolonizing).

The authors do not compare resistance movements with Liberia, probably because it does not share the same colonial history to support this argument of historical legacy; although, there is a history of marginalizing indigenous ethnic groups from the rural interior (Harris, 2012; Mulbah, 2018). However, there were problems with integrating local communities and reports of resistance when the government established quarantine, such as in West Point and mandatory cremation of bodies (Epstein, 2014; Fallah et al., 2016; NPR, 2014). In addition, there were low levels of trust in government institutions, despite the outbreak mostly affecting the capital area (Blair, Morse, and Tsai, 2017). Research shows that lack of trust correlated with behavior change, meaning those that did not trust the government and its policies were less likely to comply with control measures such as safe burials (Blair, Morse, and Tsai, 2017). However, lack of trust did not correlate with biomedical knowledge, meaning those that did not comply with emergency management still understood the risk factors of EVD. These challenges also appear in future outbreaks.⁷⁶ Historical analyses of SSA countries may not be able to explain everything, as focusing on

⁷⁵ These are the community engagement strategies discussed in section 2.6.

⁷⁶ Vinck et al. (2019) conduct a similar survey on trust in the 2018 EVD outbreak in the Democratic Republic of Congo. Community trust and support can be undermined when they see a contrast in the rapid mobilization to contain EVD, but the failure to protect civilians from chronic conflict or other long-term crises.

colonial legacies may leave out a country like Liberia as an anomaly, but it is very similar in many respects.

Liberia was promoted as a model for post-conflict development, but the outbreak revealed that state-building policies were limited (Abramowitz, 2014; Pailey, 2017). Abramowitz (2014) narrates how an entire family succumbed to EVD. Relatives had called the state-run Ebola hotline, but no one came to transport the sick. Only afterward when they passed, did a burial team come to remove the corpses. A surviving relative said that the state cared more for dead bodies than for the living. However, the problems were structural according to Abramowitz (2014). This means that despite international support and MHSW prioritizing health issues, there still lacked investment in meso-level health administration, such as having someone to answer the phones. Thus, local efforts in Liberia, such as triaging sick person at homes, isolations, or door-to-door health sensitization, were to compensate for the collective failures of state and international aid institutions. These were responses to structural violence (Abramowitz et al., 2015).

Pailey (2017) builds on the narrative of structural violence and argues that individual actors assumed public authority to respond to the crisis. These are actors in Liberia and from the Liberian diaspora. Ordinary Liberians used individual and collective resources that complemented and competed with government efforts. This also means that external organizations in the United States and United Kingdom had public authority over the government, which argues that a parallel system of service delivery worked. However, she argues that these are Liberian-owned solutions since these are affiliated with the diaspora. These solutions such as safe burials and caregiving provisions, were community-centered and built on a collective identity.

The key message from this section of literature is the demand-side perspective of the “bad behaviors” explained in chapter one (Johnston, 2015).⁷⁷ Local communities continued with the ‘risky’ behaviors not solely because of cultural and religious mores, but because the government and aid response failed them.

2.7.2 Supply Resources and Engage with the Community

⁷⁷ The discussion on how global health governance policies performed in the EVD outbreak and other health interventions, such as HIV/AIDS in section 1.2.3 and 1.6.2.

According to Cenciarelli et al. (2015), Fallah et al. (2016), Fu, Robertson, and Burnham (2015), and Lokuge et al. (2016), the initial challenges included working with untrained local healthcare workers to manage suspected and confirmed cases of EVD. Additionally, securing trust from community members and addressing rumors, misinformation, or miscommunicated messages that were part of the information failures in the market. Dhillon and Kelly (2015), Fu, Robertson, and Burnham (2015), and Laverack and Manoncourt (2016) say that the use of dynamic communication strategies such as peer education or “listening” to the community, and respecting local perspectives were key strategies to changing behaviors and gaining compliance from “resistant people”. They also say key stakeholders, such as village elders and chiefs can act as brokers so that humanitarian agencies can enter and engage in public health interventions.

This discussion depicts a dialogue with the community and local perspectives are considered. In a sense, the community’s voices are heard, and knowledge was produced to change perceptions. However, according to Laverack and Manoncourt (2016, p. 81), “We observed that one reason why the outbreak has persisted may have been that overall, the response did not deliver bottom-up approaches that could build a dialogue and promote self-management, to convince those families and communities that were unwilling to change their traditional practices.” Although Laverack and Manoncourt (2016) describe the Anthropological approach of engaging in dialogue as bottom-up participation, they do not capture how community stakeholders’ voices were scaled up in a coordinated fashion.

Elemuwa et al. (2015) say that EVD in Nigeria was contained partly because of the active involvement of community and traditional leaders in the development of communication and social mobilization activities and materials.⁷⁸ However, in their summation of the key principles that made this a successful strategy and what can be used for other EVD outbreaks, this principle was ignored. Six out of the 11 points were biomedical interventions, including the use of an experimental vaccine. The only principles related to the demand-side barriers were changing the message to emphasize treatment and social mobilization via print and social media (Elemuwa et al., 2015). These public transcripts acknowledge community engagement and participation, but do not examine how central these efforts are to systematically stop EVD transmission and deaths.

⁷⁸ This article uses the term, ‘social mobilization’.

2.7.2.1 Liberia

Fallah et al. (2016) discuss how community-based initiatives in Liberia worked instead of top-down policies of quarantines and body collections mandated by external partners and the government. They say that decision makers in Monrovia do not often consult with local communities who are affected by these policies. Therefore, these procedures tend to be insensitive to the community's needs and infrastructural constraints can make policy implementation nearly impossible, such as the lack of running water and overcrowding in the slums of central Monrovia. Instead, community, religious, and traditional leaders were invited to an open meeting in September 2014 to discuss the EVD response in this district and contribute their thoughts. Of the people who came, they were recruited and trained for surveillance and outreach efforts.

In late November 2014, focus groups were held in Monrovia to try and understand how to make the response efforts better. Initially, the WHO and the government wanted to offer cash incentives to encourage contact tracing and referrals (Kutalek et al., 2015). However, participants said that would disrupt social cohesion in communities and instead suggested that better resources are provided to isolate communities and health centers, in addition, to set up reliable communication networks between patients at the Ebola Treatment Centers (ETUs) and their families, and to include EVD survivors in mobilization and outreach efforts (Kutalek et al., 2015). However, like Fallah et al. (2016) and Laverack and Manoncourt (2016), it is not clear how these are bottom-up approaches.

MSF argues that by collaborating with the community, training health workers and health promoters, and bringing clinical resources had resulted in a decline in EVD cases in Lofa County as early as August 17, 2014 (Sharma et al., 2014). One of their strategies, influenced by community engagement, was to build the local ETU without high opaque walls. Families could visit by either speaking with patients across a fence or be inside while wearing PPE. This made families more willing to bring sick persons to the ETUs. They recommend engaging more with the community to change health seeking behaviors.⁷⁹

The first NGO-led meeting with traditional leaders was in January 2015, nearly a year after EVD was identified in the country (Ministry of Information, Cultural Affairs, and

⁷⁹ Health seeking behavior is any action taken by individuals, who perceive themselves to have a health problem, to find an appropriate remedy. See Oberoi et al. (2016), Peng et al. (2010), and White and Dull (1997).

Tourism, 2015). However, in some remote areas such as southeastern Liberia, a chiefs' taskforce was created, along with the county health team and NGOs to handle smaller outbreaks (Hagan et al., 2015). They used available public health resources and social capital to implement contact tracing, even though the bulk of aid resources was concentrated near Monrovia. The authors say this demonstrates the effectiveness of public health resources when TLIs exercise political and legal authority during a crisis. Indeed, there is a correlation between social capital and emergency management in communities that were studied elsewhere such as the North American blackout of 2003 (Murphy, 2007). However, resiliency depends on the type of social capital and external factors too. Nonetheless, Hagan et al. (2015) encourage replication in other remote areas where central administration resources are unable to reach the people.

However, the Liberian government created emergency management regulations, such as quarantines and often did not consult with TLIs (Pellecchia et al., 2015). These regulations included penalties for violators and possible prosecution under the state (NPR, 2014). Although there were recommendations for working with community leaders (Hagan et al., 2015; Kutalek et al., 2015; Sharma et al., 2014), it is not clear if these strategies became national policy or in some cases, who the community stakeholders are. Nyenswah et al. (2016) say a coordinated national campaign to engage traditional and community leaders was not enacted until November 2014; however, it was mainly by providing traditional leaders with mobile phones to report suspected cases.

2.7.2.2 Sierra Leone

The WHO and MSF established an office in Kailahun and they implemented a biomedical strategy. However, they faced community resistance, making their efforts less effective (World Health Organization, 2014a). By July 2014, more paramount chiefs were recruited to the Ebola district taskforce and trained alongside other volunteers for disease surveillance. "We went to see all the others to convince them to join the fight," recalls Dr. Yoti. "We also included the head of the interreligious council, so mosques and churches would also spread the appropriate messages," (World Health Organization, 2014a). According to this narrative, it was the WHO and other NGOs that discovered this "Kailahun approach," and began applying it to other affected areas. However, this contradicts the interview that the Director-General gave to the New York Times, regarding the role of the

WHO quoted in chapter one, section 1.6 (Fink, 2014).⁸⁰ Lokuge et al. (2016) also describe the successful control of EVD through community engagement in Kailahun.⁸¹ MSF recruited and trained contact tracers and community health workers alongside the District Health Management Team. They also recruited community health promoters, described as respected individuals to, “conduct health promotion activities in the village, focused on behaviour change related to risk factors for EVD transmission (caring for sick people and burial practices), prevention, health seeking behaviour and the services provided by the EMC,” (Lokuge et al., 2016, p. 7).

In Olu et al. (2016), an epidemiological survey of contact tracing was analyzed in the Western Area District along with ten informant interviews from June 2014 to August 2015. The study reveals weaknesses in contact tracing activities in this region, such as missed contacts, lack of community trust, and movement after the quarantine was enacted in September 2014. The Western Area⁸² is a mainly urban region and is dominated by state institutions. Thus, it is not clear in this paper how community-level leaders were involved.

Weaknesses in community engagement and coordination could have been due to a dysfunctional response in the first year, as examined by Ross, Welch, and Angelides (2017). When the Ministry of Health and Sanitation (MOHS) was leading the response, informants reported in-fighting over money, lack of data sharing (e.g. Ebola cases), and poor strategic planning. Additionally, this ignored an existing response infrastructure within the Office of National Security that incorporated traditional authorities, local structures, and MOHS. By the end of 2014, the National Ebola Response Center was created to lead efforts, however this created tension between MOHS officials who felt sidelined and those working under the new response umbrella. For example, the WHO recruited 25 persons from a district council without realizing they were in an intrapolitical fight against the APC party leadership for divesting from their budget; thus, they sabotaged contact-tracing efforts in many districts (Ross, Welch, and Angelides, 2017).

⁸⁰ See page 42 for the excerpt from the interview where the Director-General said the WHO is not a first responder.

⁸¹ This article uses the term ‘community engagement,’ but it describes strategies that are top down, like the case studies in section 2.6.2. Local knowledge is not integrated but community leaders are recruited and trained to give biomedical information.

⁸² The article uses the term Western Area District, but this contains two districts. The Western Area Urban district, which is only Freetown and the Western Area Rural district, which contains peri-urban communities. There are no chiefdoms in Freetown.

In developing standard operating procedures (SOPs) in community engagement, research on assessing knowledge, attitudes, and practices of 250 participants from seven districts, reveals knowledge values and expectations for the roles for external partners and community leaders (Pedi et al., 2017). For example, paramount chiefs raised concerns about operations and mobilization occurring in their jurisdiction without their knowledge, but the authors do not explain why that would be a concern given the legal and political structures in Sierra Leone. In addition, the study is limited to geographical regions in the north and west: Western Area Urban and Western Area Rural, Port Loko, Kambia, Moyamba, Tonkolili, and Bombali districts. As explained in chapter one, EVD started in the east but the areas studied in this paper were mobilized during phase two. Additionally, there were reports as late as March 2015 that TLIs had still not been integrated into the district level response teams (Ross, Welch, and Angelides, 2017). Therefore, Pedi et al. (2017) misses some of the perceived failures of the response during the initial stages of the epidemic that could have been included in drafting universal SOPs for community engagement.

2.7.3 Hidden Transcript: Community Leaders Corrected Market Failures

Richards (2016) discusses a different narrative of community engagement in Sierra Leone. He focuses on the concept of “a people’s science”; which is an analysis of how local knowledge and beliefs shape understandings of illness. In addition, he discusses how cultural rites such as funerals, were modified during the Ebola epidemic. His thesis is that communities led the efforts to eradicate EVD. Parker and Allen (2018) and Parker et al. (2019) build on this argument that local knowledge was what changed behaviors to eradicate EVD. This section conceptualizes the market inefficiencies of information failure and social cost into this debate on the EVD outbreak.

2.7.3.1 Information Failures and Social Costs

Richards (2016) argues that top-down analyses and community engagement strategies were not effective in West Africa. As described in section 2.6, there is a biomedical strategy for handling a VHF outbreak. Thus, while guidance, such as do not eat *bushmeat*⁸³ may be theoretically correct in preventing EVD, but it was not applicable

⁸³ *Bushmeat* is any wild game. However, the only wild animal thought to be a reservoir of EVD are some species of fruit bats, while apes and few other nonhuman primates can be infected and transmit EVD too (Bonwitt et al., 2018; Pourrut et al., 2005; Pourrut et al., 2007; Preston, 2012). However, there have been serological studies to see if other animals can be infected with filoviruses such as pigs (Fischer et al., 2018), and dogs (Allela et al., 2005).

because of the context of this outbreak. Mass communicated messages, like stop eating *bushmeat* were emphasized more than other messages, such as handwashing. This misinformation created a distortion in the market.

Handwashing is just as effective at preventing EVD and other diseases, rather than avoiding *bushmeat* alone, which was a major source of protein for many rural villagers and did not fit the epidemiology of EVD in West Africa (Bonwitt et al., 2018; Richards, 2016; Seytre, 2015). In other words, after the first case in Guinea in December 2013, all transmissions of EVD was human-to-human.

According to Richards (2016), state institutions were reading from a script written abroad and not following the actual disease path in West Africa. This is not a conspiratorial analysis, as the WHO has technical guidance and fact sheets for different disease outbreaks listing standard protocols and health education on their website (World Health Organization, 2019a). However, these were implemented without considering the local context. Emphasizing handwashing in the earlier stages may have saved more lives (reduce social costs) than prohibiting *bushmeat* consumption (Richards, 2016). Additionally, because the ban was affecting the livelihoods of some rural villagers, some people even pressured their chiefs not to enforce the ban on hunting, so that they could continue subsisting (Bonwitt et al., 2018).

The message of “not touching” a sick person is seen as unethical and inhumane in West African society and arguably, in most societies. Home care of children, older relatives, and spouses are necessary and would have been negligent, if not done (Perry and Sayndee, 2017; Richards, 2016). On the other hand, advocating for home care is unethical in Western culture, as the norm is to bring a sick person to a health center for the ‘best treatment’ (Richards, 2016). Thus, home care and distributing PPE in the community had been discouraged by DFID experts predicting it may not decrease EVD deaths (Whitty et al., 2015). Richards (2016) presents this demand-side barrier due to a clash in culture and mores.

Bulte, Richards, and Voors (2018) explain social obligations in an institutional framework, stating that visiting and helping to care for the sick is a community obligation. For example, preparing and bringing food to someone in the hospital. Many ETUs banned relatives from bringing food or visiting patients when normally it is expected for a patient to come with a relative. This led many families to choose home care instead.

Chandler et al. (2015) say that public health experts need to design messages that are more culturally sensitive and engage with the communities that are expected to change their behaviors; rather than solely working with state and international officials. Information containing only biomedical content and framed in a Western context (usually to dissuade people from continuing their 'traditional practices') has not shown to lead to healthier behaviors (Chandler et al., 2015). Also, it could be argued that only biomedical information can be misleading and inaccurate.

For example, the initial information described the very visible symptom of hemorrhaging, however, very few EVD patients displayed this (Dallatomasina et al., 2015; Richard, 2016). This could be why many people did not believe that EVD was present in the communities if many patients did not have this symptom. In addition, Parker and Allen (2018) and Parker et al. (2019) discuss some information failures and mistrust of state institutions, as referenced earlier in section 2.5.1.⁸⁴ They build on Richards (2016)'s argument that communities internally adapted their behavior for safer home care and safer burial methods. Biomedical knowledge did not reduce the spread of the disease, and thus, did not correct information failures in the market as theorized in the communication toolkit (World Health Organization, 2012a). Rather, this demand-side barrier may infer trust issues, instead of lack of biomedical knowledge as discussed in Blair, Morse, and Tsai (2017) and Vinck (2019).

Abramowitz et al. (2015)'s fieldwork in Liberia also found information failures related to caregiving. Community leaders felt that training and knowledge about EVD would help reduce fear in the community; however, the information given did not reduce this. This is because the information focused on the etiology of EVD, instead of practical messages of what to do or how to keep safe, especially when caregiving. Community members already believed in Ebola and had enough biomedical knowledge to be afraid of it but did not know enough on how to respond (Abramowitz et al., 2015).

Parker and Allen (2018) argue that communities were adapting caregiving practices after volunteers from Uganda demonstrated how to rehydrate an EVD patient safely. They say many people treated at home survived and those that did not were given a dignified burial. From this perspective, we see that communities were not resisting all aid workers or

⁸⁴ This was a brief discussion of messages communicated on the radio from page 81.

interventions. Instead, they received information that was practical and relevant to them (safer caregiving practices) and implemented them. However, Boland and McKay (2018), Enria (2017), Wilkinson et al. (2017), and Wilkinson and Fairhead (2017) view these safer caregiving practices as ‘resisting’ or ineffective governance from local leaders to stop caregiving and funerals.

Thus, putting these concepts together with Jha and Chaloupka (2000)’s work on information failures and healthy behaviors, one must be careful with how we regard information and knowledge to change behavior. Biomedical content was not enough, as communities wanted information on how to best protect themselves, like being trained to use PPE as discussed in Abramowitz et al. (2015). Or, they are not willing to (potentially) starve if there is not a risk perception of getting EVD from *bushmeat* (Bonwitt et al., 2018). Additionally, the source of the information matters, as some cases noted distrust of the source (Blair, Morse, and Tsai, 2017; Morse et al., 2016; Vinck, 2019).⁸⁵ Any of these factors could cause an information failure in the market and lead to high costs.

2.7.3.2 Community-led Efforts in Sierra Leone

This literature on community-led engagement in Sierra Leone focuses on the bylaws and community-level leaders. The bylaws were a central component of emergency response as these were scaled up to national emergency laws. However, key community leaders such as chiefs, secret society leaders...etc. were responsible for enforcing them and maintaining social cohesion. Thus, this places local communities as central actors of the response.

Richards (2016) describes how a paramount chief from the Jawei chiefdom in the district of Kailahun, who is also a trained nurse, implemented a set of bylaws and fines after the first EVD case was confirmed in May 2014. However, although the paramount chief can be very influential, he could not just make the bylaws and expect everyone to obey or enforce them, especially those laws prohibiting secret society rituals and burials, as these are not governed by the chiefs.⁸⁶ The paramount chief must deliberate with society leaders, religious leaders, youth leaders, village elders, and lower chiefs to agree on the bylaws. This chief also contacted other paramount chiefs in the Kailahun District to discuss collectively

⁸⁵ These studies say trust is a determinant in health seeking behavior during a crisis. However, Morse et al. (2016) find that outside a public health emergency, trust is not a determining factor.

⁸⁶ As mentioned in section 2.4, some chiefs are secular and religious leaders govern funerals and other rites of passage. However, this varies and Richards (2016) was specifically discussing the Mende ethnic group in Sierra Leone.

implementing bylaws in their respective chiefdoms (Richards, 2016). These rules were eventually implemented to other parts of the country, when President Ernest Bai Koroma declared a national emergency on July 30, 2014 (Barbash, 2014).

Van der Windt and Voors (2020) describe EVD as a disease of social intimacy since caregivers are most at risk for infection. Therefore, there needed to be internal dynamic changes that only local institutions can implement. They use epidemiological data to show that chiefdoms in Sierra Leone that implemented the bylaws in phase one had lower EVD case incidences⁸⁷ than other areas.

However, because of the intimate nature of the disease, O’Kane and Boswell (2018) argue that this enhanced the desire for dignity. The authors say that an EVD death can be dehumanizing, where the deceased lay in excreta, vomit, and blood. No one wants to see his or her loved ones laid out this way. Thus, corpses are hastily washed and dressed before burial teams and sympathizers see them. Given this, the literature below engages on how effective the bylaws were in various communities.

Health development committees were engaged during the EVD outbreak to support health workers and the community (McMahon et al., 2017). These committees existed long beforehand and are supported by various NGOs and donors. The volunteers performed a range of tasks such as record keeping, contact tracing, community outreach, road checkpoints, and burials. Focus group respondents from the Bo and Kenema districts discuss the high efficacy of the bylaws that were passed by paramount chiefs at the request of health workers and their roles in door-to-door education of these laws (McMahon et al., 2017).

However, Goguen and Bolton (2017) argue that the EVD outbreak was a political crisis and not a biomedical one, which may have hampered the response efforts. The community’s response to Ebola had not to do with an acceptance of biomedical information, but from their own intimate experiences with the virus, such as learning to avoid close contact. They argue that the bylaws shaped the popular response, it created the right practice without necessarily changing beliefs to have peace and reconcile after the crisis (‘social forgetting’ of Ebola).

⁸⁷ In epidemiology, ‘incidence’ is the rate that new cases are diagnosed within a given period, while ‘prevalence’ is the total number of cases alive during a given time (Coggon, Rose, and Barker, 2003).

In comparing two nearby villages in a northern district, the authors discuss the tense political relations between two chiefs, Pa Ibrahim and Pa Mohamed. The first chief had a weak claim to the chieftaincy, so he tended to govern more democratically. Pa Mohamed's claim to the throne was secure; he also had close relationships with NGOs and governed more authoritarily (Goguen and Bolton, 2017). However, Pa Mohamed was a lesser chief to Pa Ibrahim and when an EVD case came to the area, Pa Ibrahim decided not to tell anyone outside the village, but more people became sick. Pa Mohamed found out and alerted the government, which led to the ousting of Pa Ibrahim. This broke relations between both villages as it was seen as an attempt to usurp Pa Ibrahim. Pa Mohamed implemented the bylaws and enforced them in his village. Goguen and Bolton (2017) say that there were no reported EVD cases in Pa Mohamed's village, whereas 25% of Pa Ibrahim's village was affected by EVD. In an interview with Pa Ibrahim, he did not think he could enforce the bylaws and change behaviors since he had a weak claim to the chieftaincy and thought it was better to protect his reputation as a democratic leader despite the amount of EVD deaths. Thus, political considerations could have affected how chiefs enforced the bylaws. Indeed, Richards et al. (2015) discuss a circumstance where villagers pressured a chief for a funeral for a well-known person, despite the knowledge of risks.

In terms of mitigating some of these political considerations, DFID responders routed all calls for body collections and burials to the District Ebola Response Centers and would sometimes take calls themselves to alleviate political pressure from local leaders (Ross, Welch, and Angelides, 2017). Nonetheless, both villages needed to reconcile after the crisis, hence a 'social forgetting' of EVD (Goguen and Bolton, 2017). The emergency period sowed mistrust among local communities and exacerbated social and political relations.

These trust issues could have affected how the bylaws were enforced. The government created community-based Ebola care centers, which allowed people in rural communities to isolate themselves if they suspect EVD. However, when these were introduced to the eastern district of Kono in early 2015, they were used to impose the bylaws, such as checking that visitors were not sick (Oosterhoff, Mokuwa, and Wilkinson, 2015). According to the authors, this reflected distrust and security problems in the district.

In interviews with community health workers in the Kailahun and Kenema districts in the eastern province and Bombali and Tonkolili districts in the northern province, Miller et al. (2018) find that community leaders played an important role in brokering relations

between the health workers and community members. This included the passage and enforcement of bylaws. Indeed, this analysis complements UNESCO's strategy to include all community leaders, including traditional leaders, in a counter-EVD response (O'Kane and Boswell, 2018). However, traditional healers were perceived as "super-spreaders" of the disease, and bylaws suspending traditional healing practices helped in this regard in Guinea and Sierra Leone (Miller et al., 2018, p. 9). In response to this, traditional healers said they should have been incorporated because of their role and influence in the communities. This indicates that not all key stakeholders may have been included in emergency management.

2.7.3.3 Community-led Efforts in Liberia

This literature on community-led engagement in Liberia discusses various strategies undertaken by different individuals and groups. A scaled-up strategy into national policy was not observed in Liberia, but the literature examines how community-level leaders assumed responsibility to care for their families and neighbors and maintain order. Thus, this places local communities as central actors of the response.

EVD cases in the country began to decline since September 2014 (Kirsch et al., 2017). This is a few weeks after PHEIC was declared. Construction started on 25 ETUs, but three never opened and many were not fully used. Eighty lower-level community care centers were planned to help isolate cases in the rural counties, but fewer than ten became operational (Nyenswah et al., 2016; Nyenswah, Engineer, and Peters, 2016). Kirsch et al. (2017) and Nyenswah, Engineer, and Peters (2016) say that when aid came, it was too little and too late to make a substantial impact on EVD cases.

Bedford and Miller (2017) say that community health volunteers and development committees shifted to community engagement efforts during the EVD outbreak since the infrastructure (existing committees and support) already existed. However, many did not receive support from NGOs or donors to do this work but continued to monitor their local communities. Consequently, community engagement⁸⁸ results varied from community to community with some volunteers treated with suspicion and others that were trusted. It may have depended on the type of work the volunteer was doing, such as contact tracing or health education.

⁸⁸ This paper uses the term 'social mobilization,' although it says that these were community-led strategies and not always through an NGO or donor.

According to Perry and Sayndee (2017), the international response in Liberia was top-down and did not consider local knowledge on EVD in a culturally sensitive context. Therefore, various communities enacted emergency management protocols such as isolations, improvised PPE, and better hygiene practices. For example, Liberian nursing student, Fatu Kekula, treated her ailing relatives wearing homemade PPE from black garbage bags to prevent EVD transmission. This made international news and was seen as a safe alternative for caregiving. However, the authors' analysis of how or why communities organized, and why different protocols were enacted is not clear. Rather, they situate the 2014 Ebola epidemic in the context of development policies as exploitive and local efforts achieving better results than the government's laws.

Rapid response and prevention efforts of local communities can have an impact. Under these extreme circumstances, caregivers can change how they give care, triage sick persons, or even suspend these practices all together (Abramowitz et al., 2015). According to the researchers, culture is dynamic and flexible during emergency periods. Community leaders discussed their optimal plans for containing EVD in their neighborhoods, such measures included isolation and a surveillance team to report and care for sick persons and perform burials (Abramowitz et al., 2015).

2.7.4 Opposing Views to the Hidden Transcripts

There is a debate on how (in)effective were the bylaws (Boland and McKay, 2018; Enria, 2017; Wilkinson et al., 2017). However, while for theoretical purposes the thesis is primarily focused on the bylaws, it is not the end-all of how traditional leaders participated during the 2014 Ebola epidemic. Likewise, since this phenomenon was only observed in Sierra Leone, it overshadows how TLIs and community leaders organized in Liberia.

Wilkinson et al. (2017) argue that the bylaws were not effective everywhere and the chieftaincy can be subject to elite capture. They specifically say that the emergency bylaws were selectively used by chiefs for corrupt purposes, but there seems to be a discrepancy in the content they discuss, and the source referred to for this information. The paper references Paul Richard's work from 2003. As discussed in section 2.4, prior work from Richards was critical of the paramount chieftaincy and its role in the conflict and subsequent governance reforms. Richards had discussed corrupt practices of forced labor and woman

damage cases that were common up to the mid-twentieth century but are not common in today's context (Fanthorpe, 2006).

Nonetheless, Wilkinson et al. (2017) say that the bylaws mobilized authoritarian structures and were not community-led or owned. Enria (2017) says there was an announcement imposing fines and jail time for those who violate state emergency laws in June 2015 in Kambia. According to the informants interviewed, the decision to increase security came from government officials in Freetown, who were under pressure to eradicate EVD in the last remaining districts of Port Loko and Kambia. Thus, this resulted in authoritarian measures to enforce this. Wilkinson et al. (2017)'s and Enria (2017)'s analyses are based on one northern district in Sierra Leone and describe enforcement as authoritarian but did not examine the indigenous deliberative democratic processes described above by Richards (2016). In other words, the formulation of bylaws through deliberation with a council of local stakeholders. These leaders are internally identified and trusted to make such decisions, as discussed in section 2.7.1 from Wilkinson et al. (2017) regarding identifying trusted leaders. Thus, per this concept of community-led engagement, it seems as if it were community-owned unless the authors feel (but was not explicitly stated) that the paramount chiefs were not part of these communities.

In Enria (2017)'s discussion of the bylaws in Kambia district, she briefly touches on a longstanding debate of an individual's rights versus the collective during an emergency. She argues that because of the political presentation of the crisis, the responsibility became individualized and an argument for containment was made. In some respects, this is true but does not consider the longstanding socio-legal foundations of customary laws and norms in these communities. As discussed above in section 2.4.3, customary law does preserve human rights via the collective and paternal responsibility (Frémont, 2009; Maimela, 2019; Mqeke, 1996). Therefore, while the group has a responsibility towards an individual's rights, an individual has the responsibility for the group's collective wellbeing. The concept of human rights through collective identity is not a feature of emergency management specifically but represents the communitarian values of the society that is reflected in their legal system.

Wilkinson and Fairhead (2017) briefly mention how bylaws helped to bring compliance to stop 'risky' behaviors. However, they say that these laws were forcefully imposed by President Koroma to all the paramount chiefs. The premise of the article is that

local communities were resisting Western-led interventions due to structural violence. However, there is not an analysis of why it was forcefully imposed and not a collaborative response or if this is part of the structural violence witnessed in local communities. Additionally, between Enria (2017), Wilkinson and Fairhead (2017), and Wilkinson et al. (2017), the analyses of why the bylaws were ineffective are confusing. On the one hand, they argue that it was authoritarian structures (paramount chiefs and military) that mobilized and implemented this, and thus were not community-owned (Enria, 2017; Wilkinson et al., 2017). On the other hand, they say that this was forced by the democratically elected government in Freetown (Enria, 2017; Wilkinson and Fairhead, 2017). However, neither sources provide further analysis on the governance of the TLIs or the state institutions on the bylaws or how the political structure allowed the state to force TLIs to do this.

Boland and McKay (2018) respond to Parker and Allen (2018)'s blogpost about the bylaws and community-led interventions during the Ebola epidemic. They disagree "that the interventions of national and international agencies were somehow unhelpful, secondary, or separate to community-led interventions" and that community leadership was consistently effective (Boland and McKay, 2018). They say that Parker and Allen (2018) presented a dichotomy of insiders and outsiders when most volunteers were Sierra Leoneans working in their communities. However, Boland and McKay (2018) do not clarify how they derive this definition of community to definitively say that the volunteers were internal community members. Nonetheless, they agree that every community experienced EVD differently, as communities affected during phase one did not benefit from a scaled up coordinated response from the government and NGOs, versus a village during phase two. They agree that the wider response may have failed Mathiane if this village was one of the earlier ones affected, but to limit aid resources broadly as a policy could have deadly consequences. Boland and McKay (2018) argue for more aid resources but do not analyze the response of TLIs and rulemaking. Thus, it is unclear why TLIs may not have always been effective and how more aid resources could have replaced poor governance.

The narrative in this section is that the bylaws passed in Sierra Leone were not effective everywhere, which may be true. However, the authors do not conduct a full analysis into which aspects of the bylaws were ineffective or how governance from TLIs was ineffective. Goguen and Bolton (2017) and Richards et al. (2015) offer a possible explanation

as to why some chiefs may choose not to enforce them, due to political circumstances or preferring a more democratic form of governing. However, the latter would be contradictory to our concept of good governance if it led to more EVD deaths (social cost).

This nuances the concept of rulemaking and enforcement in determining poor or good governance, as sometimes local leaders may succumb to political pressure from constituents. Or, sometimes as part of an emergency response, authorities may need to improvise or rework their knowledge to fit the current situation (Mendonça, Beroggi, and Wallace, 2001). Although institutional quality depends on rulemaking and enforcement, these are sensitive to external factors or new knowledge acquisition.

The literature focuses on two bylaws, the banning of funerals and at-home caregiving as evidence of poor governance since these continued in some places. However, Van der Windt and Voors (2020) have an appendix that lists several bylaws that were scaled up to national regulations, which demonstrate a comprehensive set of behavior changes. Whether these other bylaws were effective or not, has not been examined yet in the literature. The thesis fits into this debate on the empirical literature regarding local community engagement during the 2014 EVD outbreak, including how passing the bylaws in Sierra Leone can be seen as high institutional quality.

2.8 Summary

The thesis reviewed three levels of literature and identified a gap at each level. The first level of literature was on the new institutional economics theory. This framework assesses market-led economic growth, decline, or stagnation via rules and norms (North, 1990). However, this does not fully explain why people choose to cooperate. Thus, the concept of social capital helps us to understand that institutions need trust and legitimacy, but sometimes this can take the form of patrimonialism too, which can harm local development (Acemoglu, Reed, and Robinson, 2014). Additionally, since institutions are designed to address specific challenges, there is not one institution that can address all problems (Acheson, 2000). Thus, this section also discussed polycentric governance, which are multitier institutions that govern specific challenges (Oström, 1990; Oström, 1998; Sawyer, 2004). The thesis identified a gap of assessing institutions for social outcomes: the

reduction of social costs and correcting information failures (Becker and Becker, 1997; Jha and Chaloupka, 2000; Reubi, 2016).

The second level of literature discussed public health emergencies using Scott (1992)'s concept of public and hidden transcripts. The public transcript is usually accepted as the norm and a hidden transcript is rarely brought to the surface and accepted as mainstream. The thesis holds that the public transcript of public health emergencies described biomedical aid resources brought in by predominantly Western-derived international responders, resolved these disease outbreaks. This narrative did not thoroughly examine how traditional and community leaders responded. They are lumped into a general category of community stakeholders and their governance is not discussed (Allaranga et al., 2010; Centers for Disease Control and Prevention, 2007; Cohen, 2018; Enserink, 2005; Georges et al., 1999; Ilunga Kalenga et al., 2019; Lamunu et al., 2004; Médecins Sans Frontières, 2018a; Médecins Sans Frontières, 2018b; Médecins Sans Frontières, 2019; Moran, 2018; Msyamboza et al., 2014; Muñoz, 2017; Nkengasong and Onyebujoh, 2018; Okware et al., 2002; Onyango et al., 2007; Roddy et al., 2007; U.K. Department for International Development, 2011; World Health Organization, 2007; World Health Organization, 2009). Thus, because of this absence, this thesis will add the missing branch to this operational level of the literature too (section 2.6). Institutions at the community-level define behaviors and norms of the people and a top-down situational market analysis (World Health Organization, 2012a), cannot implement behavior change alone.

The third level of literature is the transcripts of the 2014 Ebola epidemic. The hidden transcripts challenged the narratives of the public transcripts, as it showed that efforts to fix the demand-side barriers through the biomedical paradigm did not work well. Therefore, it implied that NGOs and donors had poor governance of the 2014 Ebola epidemic by not fixing these market failures. The literature repeatedly mentioned specific challenges such as rumors, misinformation, 'secret burials,' and at-home caregiving (Abramowitz et al., 2015; Boland and McKay, 2018; Enria, 2017; Parker and Allen, 2018; Parker et al., 2019; Perry and Sayndee, 2017; Richards, 2016; Van der Windt and Voors, 2020; Wilkinson et al., 2017). The hidden transcripts revealed that traditional authorities in Sierra Leone passed emergency management regulations to govern the crisis. In Liberia, community leaders organized in their communities with various intervention strategies. There is a debate on whether

community leaders were effective in resolving Ebola cases and reducing deaths. However, this debate predominantly focuses on traditional leaders in Sierra Leone (Boland and McKay, 2018; Enria, 2017; Parker and Allen, 2018; Parker et al., 2019; Richards, 2016; Van der Windt and Voors, 2020; Wilkinson et al., 2017). At this level of literature, there is a gap in how the local governance of community and traditional leaders during the outbreak constitute high institutional quality.

The following chapters will support this theoretical framework with evidence collected from the field. First, there were high information failures and social costs during the 2014 Ebola epidemic, despite the WHO and domestic governments delivering correct biomedical information. Second, the response- especially during phase one, did not help to fix these market failures and local community leaders responded to do so. Third, community and traditional leaders had a role in governing this outbreak that demonstrates high institutional quality by fixing these market failures. Finally, a multitier institutional response was observed regulating supply and demand barriers; this can provide lessons for the next disease outbreak. The next chapter is the methodology chapter. This discusses data collection and analyzation methods to ensure robust and rigorous findings that support this thesis.

CHAPTER THREE: Methodology

All research projects have a systematic process for collecting and analyzing information to answer a question.

3.1 Introduction

The findings presented in the subsequent chapters are based on a comparative case study of two countries in West Africa that were the epicenter of the 2014 Ebola epidemic. One-on-one semi-structured interviews were conducted with health workers and community stakeholders in three provinces in each country. This thesis developed its research methods through a checklist created by the Critical Appraisal Skills Programme (CASP): a critical appraisal tool available for eight study designs (Critical Appraisal Skills Programme, 2018). The tool used was the qualitative study checklist to ensure a robust and problem-based approach, thereby strengthening the research design and methodology of the thesis. These methods help to understand the role played by traditional local institutions (TLIs) and aid resources during a public health emergency. The rationale and justification of the decisions made by the investigator are in response to challenges in developing the theoretical framework, data collection, and conducting data analyses.

This chapter demonstrates how an idea was conceived and molded through hundreds of hours of literature review to generate a viable evidence-based research project in the field. It is organized according to the CASP qualitative study checklist. Section 3.2 discusses qualitative research, its purposes and why this methodology can help answer the research question (Creswell, 2014; Denzin and Lincoln, 2005). Section 3.3 discusses the research design, including how the research question was redesigned as a response to challenges in theoretical development after data collection. Section 3.4 discusses the methods used during fieldwork. Section 3.5 discusses ethical considerations for conducting fieldwork. Section 3.6 discusses how the data were analyzed and structured thematically (Vaismoradi, Turunen, and Bondas, 2013). Section 3.7 discusses how the findings are considered rigorous and robust in qualitative research (Morse et al., 2002). The final two sections discuss how the findings will be disseminated and the limitations of the thesis.

3.2 Qualitative Research

Qualitative research is, “a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible.” (Denzin and Lincoln, 2005, p. 3). This is a scientific process that cuts across many disciplines and theoretical paradigms in the social sciences. It has even been a source of inquiry itself, as

Denzin and Lincoln (2005) discuss the development of historical and critical approaches in qualitative methodology. The empirical materials, such as case studies, interviews, texts, artifacts, observational, or interactional sources can be interpreted to give a picture of someone's life. Through these materials, the world is transformed into representations of the observer(s) during a specific time frame. Qualitative research gives researchers a window to view and interpret a specific event or situation.

Denzin and Lincoln (2005) describe the qualitative researcher as a quilt maker. The researcher could be an anthropologist, film maker, journalist, or social critic who is piecing together patches of empirical material to make a quilt. This process is scientific as much as it is aesthetic. Different tools (e.g. sampling methods) may be used to design the quilt and sometimes new tools are invented. The methods of interpretation may not be decided before conducting the research, sometimes, it can be done inductively. This means that interpretation can happen once the data are collected and analyzed, to draw a hypothesis.

3.2.1 How Qualitative Research differs from other Methodologies

Creswell (2014, p. 4) defines quantitative research as, "an approach for testing objective theories by examining the relationship among variables. These variables, in turn, can be measured, typically on instruments," while qualitative research is used for, "exploring and understanding the meaning individuals or groups ascribe to a social or human problem." And finally, mixed methods research involves, "collecting both quantitative and qualitative data, integrating the two forms of data, and using distinct designs that may involve philosophical assumptions and theoretical frameworks." (Creswell, 2014, p. 4). In short, quantitative research will result in numbers and statistics that provide breadth and test a theory to be true; this can be useful in a theory confirming case study. Odell (2001) describes this as a least-likely scenario where conditions or factors are highly unlikely to confirm an existing theory, yet the effects or results still confirm the theory's validity. Qualitative research makes use of the experiences and beliefs of people from their perspective (subjective analysis), giving depth and adding the human experience. Odell (2001) says a descriptive case study, which aims to document an important event, aligns well with qualitative research.

Indigenous methodology views knowledge as relational, and therefore it cannot be discovered or owned (Wilson, 2001). Research in this framework goes beyond 'culturally sensitive' because traditional research paradigms are imperializing and Eurocentric. Therefore, these do not justly convey the knowledge and experiences of indigenous persons (Hart, 2010). In this paradigm, the perspectives of indigenous persons are not presented vis-à-vis Western worldview, but these are part of an ontology and epistemology, hence, needing indigenous research methods to convey them. Smith (2012) says that this is not a total rejection of all theory, research, or Western knowledge; however, the theories and methods used should be critically contemplated before applying them. In other words, as researchers, we should ask if current methodologies and theories help us understand the phenomenon or the human subjects, or perhaps, disempower them.

3.2.1.1 Disadvantages with Qualitative Methodology

However, there are some disadvantages to conducting qualitative research. One example is the time-consuming procedure of data processing (Franklin, 2019). When designing the research project and fieldwork for data collection, most researchers will plan for time to collect the data (such as conducting the interviews or focus groups) and time to analyze the data, however, it can take time to process the data too. For this research, all interviews were audio recorded and transcribed into written transcripts before being imported into a data analysis software. Transcribing can be a long and tedious process, especially if interviews are longer than thirty minutes, which is the case for most of the interviews for this research. On average, it took about four hours to create a written transcript and there are field notes and a diary that also contains observational and interactional materials too. It takes time to create the data, whether it is done after each interview session as brief notes or as a bi-weekly diary entry, time must be allotted to create the qualitative data and add these to the analysis.

As qualitative research can be time consuming, it generally means that studies are smaller than the ones in quantitative research. For example, some quantitative research projects that use statistical modeling can involve hundreds or maybe even thousands of sources that are inputted into a software for analysis. However, it is rare to find qualitative research that involves a high number of participants or informants who were interviewed. Many qualitative studies also tend to be geographically centered in a specific location, such

as a neighborhood, village, or township. Research, like this one, where informants come from different towns within a country as well as from different countries, are rarer and hence more valuable. However, qualitative research can be harder to generalize to other scenarios (Denzin and Lincoln, 2008).

Another disadvantage is that data can sometimes be contradictory or maybe even wrong. By this, I mean the informants interviewed may have imperfect memory or only remember events from his or her perspective. However, these limitations are not only found in qualitative methodology. To help mitigate this, informants were sourced from different locations and key facts such as dates are referenced against the literature when possible.

As described below, this thesis and data collected are based on a qualitative methodology, in which one-on-one interviews were conducted with key informants about the healthcare system during specific time sets: after the civil conflict period, during the 2014 Ebola epidemic, and present day. The data are written transcriptions, where words and phrases were analyzed to draw themes. Once the data were processed and analyzed, the themes and concepts were used to draw a hypothesis.

3.2.2 Choosing Qualitative Methods

A qualitative approach is preferable for an in-depth understanding of the human experiences and relationships between institutions. To achieve the research objectives of understanding the role and effectiveness of TLIs and aid, a statistical or numerical output would not fully answer these questions. For example, a quantitative study that took place in the Kailahun District of Sierra Leone used epidemiological data and mathematical modeling to assess the impact of control measures placed in the district (Lokuge et al., 2016). It found that community-level response activities, such as contact tracing and health promotion were vital to control the disease outbreak. It briefly described these measures, but only in a cursory manner to demonstrate how community behavior correlated with a disease spread. The causes, motivations, or relationship between stakeholders and the community were absent. Data on community engagement would have provided a more in-depth understanding of significant contributing factors to the impact of these measures.

Furthermore, there is a shift to include qualitative data and methods in Institutional Economics. Skarbek (2020) argues that in general, Economics is a discipline defined by its quantitative methods, rather than a singular topic and using these methods for institutional analysis may not provide us with all factors of causal mechanisms. This is because these methods reduce the factors to simple variables and lose crucial parts of their meaning. Therefore, qualitative data is preferred to provide a 'thick description' for generating new theories and analyses. And by 'thick,' we mean an understanding of multifaceted and multidimensional characteristics (Skarbek, 2020).

This research uses qualitative methodology because the thesis was exploratory, meaning that, coming into the field, there was not a well-defined research question, but one that was open to being shaped by emerging themes and categories. Thus, as explained in section 3.4.1, a broad open-ended questionnaire was developed to collect information, and responses were long and in narrative form, often with probing questions added. It is also why the project was designed as a case study, as explained in this section, there was an initial intrigue regarding a specific event: the 2014 Ebola epidemic. A comparative case study was designed to explore the parallels and differences in the response and outcomes of the cases. Since the case study was investigative and exploratory, qualitative research is a good option as it generates considerable information, especially some that may go beyond the original research question.

3.2.3 Selection of the Countries

Liberia and Sierra Leone are fit for comparison because they have a similar recent history, being embroiled in civil wars and have lost an entire generation due to a lack of health, education, and prosperity opportunities (Bøås, 2001; Harris, 2012; Wright et al., 2015). They both experienced the 2014 Ebola epidemic in which thousands of people were affected and the healthcare systems were overstretched. They share similar regional features and are heavily indebted poor countries as defined by the World Bank (World Bank, 2012); hence, they are both at a stage of post-conflict recovery and development.

However, as discussed in chapter one, in sections 1.3.4 and 1.5, Liberia was heralded as making the greatest progress in its health status, as it had the highest increase of life expectancy in the world of 19.7 years from 1990 to 2012 (World Health Organization,

2014b). According to Nkwanga (2015), international donors used this achievement as proof of the success of the development/systemic aid programs. On the other end of the spectrum, Sierra Leone was found to continue having the highest maternal and infant mortality (MMI) rates in the world (Sharples, 2015). However, under pressure from international advocates, the government released the Free Health Care Initiative (FHI) in 2010 to provide free health services to pregnant and lactating women and children under five to improve these indicators. However, despite the discrepancy in these health indicators, neither country was prepared to identify and contain the Ebola Virus Disease (EVD) in those crucial primary stages in the Spring of 2014.

Thus, given the historical, geographical, and economic similarities, combined with the intriguing differences in development and health indicators, designing the project as a comparative case study seem likely to reveal some interesting and previously unknown findings.

3.3 Research Design

In the social sciences, a research design is an overall strategy or procedure used to collect, measure, analyze, and integrate different components logically and coherently (De Vaus, 2001). The research question determines the type of design that will be used. There are many types of designs: a case study design, causality study, cross-sectional study, or systemic review, to give a few examples (De Vaus, 2001). This thesis uses a comparative case study design.

3.3.1 A Comparative Case Study Design

The design is a comparative case study approach in which two countries are being examined to answer the research question. Qualitative methods are employed to uncover opinions and perspectives on the problems of mobilization of people and resources during a public health emergency. According to Odell (2001), a comparative case study can create an interesting puzzle for research. A case is selected because as researchers, we are interested in the effect of an event or situation, and therefore look to analyze the causes and how they are correlated. When two cases are selected to illustrate a difference in causes and effects (Odell, 2001), it makes for a comparative case study.

Some comparative methods are employed too, specifically, a comparative analysis of field data and secondary data are used in this study, such as official epidemiological data from the World Health Organization (WHO) and data from Afrobarometer surveys. These are discussed in section 3.3.4, below. Thematic analysis is used to compare the primary data from the semi-structured interviews. The case study method relies on the use of multiple sources of evidence to investigate the research question. This includes analysis of economic, health, and governance data in both countries; these secondary data were compared in chapter one.

The thesis did not take a fully deductive approach to conduct a comparative case study, but rather it adopted a sequence of inductive and deductive approaches, and the initial research question was informed by previous research into the existing theoretical backgrounds. Initially, there was interest to look at the three countries that were mainly affected by the 2014 Ebola epidemic: Guinea, Liberia, and Sierra Leone. However, as mentioned above, Liberia and Sierra Leone have striking similarities in their history and legacy, and due to the time and word limitations of a Ph.D. thesis, it was decided that comparing two countries already pushes the upper limits of these constraints. Another advantage of doing a comparative case study in qualitative research is that the findings are more likely to be generalized and, if there are patterns across two or more cases, then we can think differently about how a policy or strategy is or is not working.

3.3.2 A Re-Design of the Question

At the beginning of this doctoral research, the approach was a multilevel analysis of macro (global), meso (domestic/state level), and micro (local or community) health governance arrangements comparing interventions and strategies of the chronic disease pandemic of HIV/AIDS and the 2014 Ebola epidemic. However, after fieldwork in both countries, there was a lack of access to global and national level actors. Thus, it was decided to narrow the scope of the project to compare responses during the outbreak from community-level leaders.

The major themes drawn are from what informants discussed regarding the role of TLIs during a time when state institutions and international actors did not adequately respond or deliver resources to contain the EVD spread. A framework was theorized with

the concepts of public health emergencies, community engagement, polycentric governance, and institutional quality. The nexus of these concepts are institutions, and the contribution that this research makes is how TLIs govern during a public health emergency.

3.3.3 The Literature Search

The literature surveyed for this work are from diverse perspectives drawing from the fields of African studies, anthropology, biomedicine, conflict/security studies, development studies, economics, epidemiology, foreign policy studies, governance, history, international relations, philosophy, political ecology, political economy, public health, public policy, and sociology. Public health crises in developing countries and the role of donors and external agencies is a widely explored field, however, the examination of traditional leaders at the micro-level is less explored and even less understood for health promotion. The broadness of this literature was mainly from the first and second year of research, where sources were recommended or sought through the references.

Once the major concepts of the thesis were identified, an intensive literature search narrowed the literary sources that identified those concepts of a public health emergency, aid resources, traditional institutions, and community engagement. These sources discussed in chapter two were academic sources, gray literature, and news sources. The literature review discussed institutions in the new institutional economics framework, understanding behavior change in rulemaking, monitoring, enforcement, and social capital during public health emergencies and the 2014 Ebola epidemic. The findings of this thesis regarding bylaws and rulemaking address a gap in these two levels of literature.

In addition, because this research is an evidence-based case study, the thesis fits into two debates as demonstrated in the second chapter. The first level is the theoretical debate on governance outcomes of rural-based institutions and the second level is the empirical literature on the community engagement during the 2014 Ebola epidemic.

3.3.4 The Secondary Data

One source is Afrobarometer and it was discussed in chapter one (Afrobarometer, 2019). These surveys analyze broader perceptions of governance, society, and include local government and traditional leaders. Thus, when we compare both countries' institutions,

we can appreciate the complexity and depth of how local citizens view democratic and governing structures. This gives a more nuanced picture than the World Bank's governance indicators. Liberia and Sierra Leone are comparably similar, in that state institutions, local and national, are viewed less favorably than traditional ones.

Second, there are epidemiology data, which are drawn from a variety of sources (World Health Organization, 2012b; World Health Organization, 2016b; World Health Organization, 2016c; World Health Organization, 2016d). Most of these were discussed in chapter one as an overview of health status in the case study countries and perceptions of health governance. Many of the indicators are aligned with the United Nations' Millennium Development Goals (MDGs). Therefore, recipient countries of aid, receive support for vertical interventions for specific diseases or conditions and not a horizontal strengthening of healthcare systems. Any improvements in these performance-based indicators are seen as favorable changes in health governance. And these indicators align to the overall governance strategies for recipient countries of aid, as the MDGs are part of and funded via the Poverty Reduction Strategy (PRS).

The epidemiology data contextualize governance and health infrastructure, except for the WHO's Ebola situation report, which was published during the outbreak. We understand how healthcare systems were monitored and evaluated and how this may not have captured the entire picture of health governance. Furthermore, data from Afrobarometer depict broader governance performance of state and traditional institutions that can be discussed along with primary findings.

The WHO's Ebola situation report will be discussed in the following chapters (World Health Organization, 2016d). The report gives an on-the-ground assessment of the emergency response and total of epidemiology cases: new cases and death cases due to EVD. However, there were limitations in collecting the data, as the WHO officially intervened nine months after the index case in December 2013. It was up to local ministries of health to trace, confirm, and follow up with EVD cases. In addition, the WHO uses different definitions of 'suspected, probable, and confirmed' cases than what the local ministries use.

The number of deaths was divided by the total number of those affected by EVD and multiplied by one hundred. This was done to yield a percentage number of EVD deaths. This method is also used for calculating the case fatality rate or case fatality ratio in

epidemiology (Gordis, 2009; Harrington, 2019; Kanchan, Kumar, and Unnikrishnan, 2016; Liu, 2018). This information can tell us disease severity, as well as environmental factors, such as available treatments and quality of care (Harrington, 2019). Thus, this can be used to interpret the environmental factors that differed in Liberia and Sierra Leone, such as getting EVD cases into care. However, because the data were not collected by the principal investigator and the disease outbreak lasted for a few years, accuracy cannot be completely certain. Nonetheless, the WHO is an internationally recognized and trusted entity for technical guidance and policies. Therefore, this is the most accurate and widely sourced information on EVD cases that we have available.

3.4 Fieldwork

This section discusses strategies used in the field to develop a data collection tool (questionnaire), data collection, and leaving the field in an ethical manner. Access to key informants was gained through field supervisors and gatekeepers as well as various sampling methods. Fieldwork was conducted in West Africa from January 2017 until July 2017, arriving in Sierra Leone first and then traveling by air to Liberia in mid-March. Access, quality assurance, and administrative clearance were overseen through field supervisors in each country.

3.4.1 The Data Tools

The data tool is a questionnaire of open-ended questions that were broad and chronologically based to elicit a narrative response. The first five questions discuss the baseline, they ask about the current challenges that health workers face and how the healthcare system evolved since the end of the conflict period. Both countries ended their civil conflict a year apart from each other. The next four questions ask the informants about the 2014 Ebola epidemic and how she or he would evaluate what happened. The remaining questions discuss the present day since the outbreak, how health workers see themselves as governing the healthcare system, and their perspectives about the future of health in their respective countries. In total, there are seventeen questions, not including the probing questions. This questionnaire was developed before going into the field, believing there would only be a chance to speak with clinical professionals. However, after a discussion with

the field supervisors, it was revealed that there would also be an opportunity to interview local community members who assisted during the outbreak in a nonclinical setting.

A different questionnaire was drafted because, as community members, they may not have known detailed information about the health facilities. In addition, it included broader questions about health policies and community engagement in health interventions. This separate questionnaire had only nine open-ended questions. It began with a baseline question regarding the evolution of the healthcare system, then it asked informants to discuss what happened during the 2014 Ebola epidemic. It also engaged participants on matters of political decisions and relationships, community expectations, the stigma of survivors, and perceived challenges to quality healthcare. Copies of the surveys, pre- and post- pilot are in Appendix A.

The data tools were created broadly because there was not a strong predetermined theoretical framework before entering the field. However, the questions on the 2014 EVD outbreak and post-outbreak were designed to be evaluative on governance and performance, and hence, to elicit more theoretically driven data. Additionally, broad and open questions helped to obtain a narrative response, and probing questions were used to explore certain themes or issues that came up. The advantages are that the information revealed could give new insight into a problem or even generate further questions for research. However, the disadvantage could be the lack of consensus or major themes to develop, if the interviews are not guided or probed deeply enough. However, experience in interviewing techniques could help mitigate this by staying within the topic and probing questions.

3.4.2 Data Collection

Data collection consisted of one-on-one semi-structured interviews with key informants on site that provided reliable and comparable data. A semi-structured method is a formal interviewing process but provides flexibility to go off-topic, as this may reveal different aspects of the problem, or a new way of seeing the solutions (Low, 2013). The main finding regarding bottom-up rulemaking from TLIs was not the main question that initially was to be investigated. The original purpose was to investigate the causes of the 2014 Ebola epidemic and possible linkages to global health governance and development

interventions. However, soon after hearing about the bylaws and integration of these laws, it was evident that an expansion of the informants' pool to include community stakeholders⁸⁹ was needed. Also, a different data tool was created to find out more about their role in the outbreak specifically and the healthcare system more broadly. All interviews were conducted one-on-one unless the informants requested an interpreter. Each person was interviewed once.

A one-on-one interview format was chosen for confidentiality, comfort, and time availability of the informants. Having a one-on-one conversation rather than a focus group can take less time to organize. In focus groups, one would have to coordinate the schedules of multiple people as well as take into consideration of who is in the room. Some people may not feel comfortable speaking up in a group setting or some voices may overpower another, especially where language barrier is a concern. This may lead to someone who felt more comfortable conversing in English to speak for the group. A one-on-one format creates a more relaxed environment where the informant feels like she or he is having a conversation with the researcher. Moreover, the informant may divulge information that may not have been revealed in a setting where multiple parties are present. It is also easier to redirect the conversation if the topic goes too far off-track. Also, since the interviews were audio recorded as opposed to video recorded, one-on-one interviews were preferred, because if there are too many voices on tape, then it can make transcribing difficult to discern which informant is speaking.

3.4.3 Field Supervision

There were two field supervisors whom each had experience conducting research in the selected countries, and thus, understood the local administrative, ethics, and cultural settings to collect high quality data. Prof. Marda S.T. Mustapha from The College of Saint Rose for supervision in Sierra Leone and John S.M. Yormie Jr., Executive Director of the Liberia Research and Development Network for supervision in Liberia. This included the

⁸⁹ Community stakeholders are key informants who volunteered, organized, or assisted during the 2014 Ebola epidemic. Some of the stakeholders may be knowledgeable on health issues, but do not work as a health worker in a clinical setting. Chapter four presents a breakdown of their roles. No informants were identified as 'service users.' The term, 'community stakeholders' is used to throughout the thesis when referring to nonclinical informants, unless otherwise specified.

advantages and challenges of mapping and choosing locations, interview questions, communication challenges, and sampling methods for accessing key informants.

A pilot interview was conducted with each field supervisor. However, the questionnaire had already been drafted and reviewed by the ethics committee at the University of Westminster. The pilot interviews helped determine if the questions were appropriate, how they would be understood, and any areas that may come up for probing. Question number ten, “How did health workers organize during the outbreak?” was changed to, “What are the incentives to keep health providers working?” The word ‘organize’ may not be understood in this context and it broadened up the question. This got more narrative responses from informants regarding the working conditions and satisfaction levels.

3.4.4 Gatekeepers

The role of the gatekeeper was very important in gaining access to health workers and other key informants. In short, gatekeepers control access at every level of the research process, in formal settings, such as government institutions or in informal settings (Franklin, 2019; Mandel, 2003; Reeves, 2010). The gatekeepers introduced me to many key informants in the field, who were interested in the research project. Also, they made introductions to people who engaged in contextual conversations with me, regarding the specific event of the 2014 Ebola epidemic and the development process at large. These ranged from senior aides in the executive office to community people who were affected by the disease. It was the field supervisors who introduced me to a few gatekeepers.

In Sierra Leone, there was a main gatekeeper who knew the rural provinces well and understood the local Mende dialect and traditions, especially when approaching the paramount chiefs and district medical officers. Paramount chiefs are the local political elite who operate with great authority and respect in these communities. So, in these instances, a gatekeeper led to another gatekeeper. In Liberia, I had a gatekeeper in the Ministry of Health in Monrovia that provided introductions to the county health officers, who in turn gave access to the officer-in-charge of the health facilities. In the rural provinces of Sierra Leone and Liberia, gatekeepers who were affiliated with nongovernmental organizations (NGOs) were also approached for access to key informants.

3.4.5 Mapping

Three geographical provinces that were initially and heavily affected by EVD, were selected in each country (BBC News, 2016; Bullard, 2018). In Sierra Leone, these were the districts of Bo, Kailahun, and Kenema, and in Liberia, these were the counties of Lofa, Margibi, and Montserrado.

In Sierra Leone, the fourteen districts are secondary levels of government administration, this means that the country is divided first into four regions: North, East, South, and Western Area. Under that, each region holds a few districts, in the eastern area are the Kailahun, Kenema, and Kono districts; and Bo District is part of the south. Under each district are chiefdoms, this is where the paramount chief has jurisdiction over his or her constituents. Resources are channeled through the districts, so each district has a district medical officer and district medical health team and these local actors know the health facilities and community stakeholders in the district. Each district has a headquarter city. For example, Bo Town is the headquarter city of the rural district of Bo in Sierra Leone. Thus, Bo Town would be an urban setting, while Gerihun or Telu, which are located outside the headquarter city, but within Bo District are considered rural settings. The definitions of urban and rural were discussed with the field supervisors and gatekeepers in both countries.

In Liberia, the first level of government administration is the county level and there are fifteen; each county has a county health officer and the county health department. Each county is further divided into districts and the districts have councils and a district health officer; then there are cities and then chiefdoms headed by a paramount chief. Hospitals tend to be in the urban areas and were converted into Ebola Treatment Units (ETUs) during the outbreak. Each county in Liberia has a capital city and these are defined as urban areas. However, since two urban counties were selected, then all cities visited in Margibi and Montserrado County are urban. The only rural county, Lofa, has rural townships from which to select informants.

The capital of Liberia, Monrovia, is included in the Montserrado County mapping, which was initially and heavily impacted by EVD. However, the capital of Sierra Leone, Freetown, did not fit the criterion and was not included. Thus, the mapping and sampling skew rural dominant for Sierra Leone and urban dominant for Liberia. This mapping is

similar to another comparative case study that visited sites that were highly affected by EVD (Miller et al., 2018).

3.4.6 Sampling Methods

Key Informants were sampled with two methods: snowballing and target sampling, depending on the size of the health center. These are called purposeful sampling methods and are preferred as there was a specific criterion of people to be interviewed: primarily healthcare workers and if possible, volunteers or authorities who participated in the response.

Purposeful sampling is, “a technique widely used in qualitative research for the identification and selection of information-rich cases for the most effective use of limited resources (Patton 2002),” (Palinkas et al., 2015, p. 534). Thus, the selection was not random; I was seeking individuals who have knowledge regarding a specific phenomenon, so a randomized selection would not fit the scope of the research. Furthermore, one must consider the target population too. The first chapter discussed how health human resources (HRHs) were very low in these two countries, especially since the conflict period displaced many people. In addition to that, health workers (and caregivers) were the main victims of the EVD outbreak. At the time of fieldwork, the population of health workers was fewer and farther between.

A variety of purposeful sampling methods were used to seek informants for interviews, and the definition of a health worker was broadened up. In the beginning, it was planned to only speak with doctors and nurses, however, we encountered very few doctors, especially in the rural areas, and more nurse’ aides, community health workers, pharmacists, and laboratory workers. Since, in these areas, it is common practice for a patient to visit the laboratory for blood tests and be given a prescription for medication, laboratory workers were included in the sampling.

3.4.6.1 Snowballing or the Chain-Referral Method

Thus, because the population is small and can be difficult to access, snowballing is a helpful way to recruit informants who fit the criterion (Heckathorn, 2011). Snowballing or chain-referral sampling means a researcher asked the participant or informant if she or he could make an introduction to another potential person that would participate. Used since

the 1960s, it is sometimes seen to have bias and is also called a 'convenience method'. However, the intent of recruiting from a select pool where people are similar is the purpose of the research. The only limitation is that the chains did not get very long, so another health worker was approached to see if another chain may get started again. The only place where the chain-referral was exhausted was in the Kenema District in Sierra Leone, and therefore, another facility was visited to try and get close to ten interviews for the area.

In settings where more than seven employees were present, snowballing was used. However, when the chain of referral was broken, then I approached another employee at random and asked if she or he would be interviewed. In medium to large facilities, this method is preferred as the researcher is introduced by a trusted colleague and it helps to identify those with expert knowledge, such as the experience of working in the ETUs or with an NGO as a volunteer. However, the chains did not get longer than three persons before being broken, and therefore needing to approach another health worker at the facility.

3.4.6.2 Devising a Target Sampling Method

A strategy was devised for smaller clinics where less than five employees were present. Everyone at the facility would be approached for an interview, hence targeted. Some units have very few personnel at the facility which meant that after arriving and being introduced to the officer-in-charge, it did not make sense to do a chain referral. Everyone knew a researcher was there and was usually available to speak. Targeting is a purposeful method, as the units fit the criteria. This means a unit (health center) was targeted and everyone within that unit was approached for an interview when we visited.

As for the interviews with stakeholders, all these informants were purposefully targeted and approached for an interview, again this is to seek a defined subpopulation with knowledge regarding a specific phenomenon. After discovering that there would be a chance to interview community stakeholders and creating a new data tool, these informants were sought after because of their role in the response. Their narratives gave another layer of validation to what health workers believed were strengths and weaknesses within the healthcare system too. Therefore, with the consultation of field supervisors, gatekeepers, and after mapping, targeting, and chain referral, key informants who had specific information for the research project were sought and interviewed. The sampling excluded community members who had no role in assisting during, or in governing the outbreak; and

thus, the findings do not include a strictly 'service user' perspective. At least one stakeholder per district in Sierra Leone or per county in Liberia were interviewed. In Sierra Leone, more stakeholders were interviewed than Liberia, because of the unique circumstances of bottom-up rulemaking that was part of the national response.

3.4.7 Leaving the Field

Leaving the field, after conducting qualitative research, involves complex emotions of fatigue, intellectual enthusiasm, sadness, and a new perspective on the world. Thus, for ethnographers, field participants, and other researchers who engage in relationship-building and narration during the data collection, concluding the field research is more than a wrap up of notes. Bloor and Wood (2006) describe this as a social process of withdrawing, which can disrupt relationships, especially ones that were built to access key informants. A researcher's departure can be seen unfavorably and may hamper future field projects, with participants less willing to engage (Shaffir and Stebbins, 1991). This can be concerning for Liberia and Sierra Leone, where the EVD outbreak has also brought a huge surge of research interest. Gallmeier (1991) acknowledges this challenge but also remarks that disengagement may not have always been due to a lack of engagement on behalf of the researcher. Sometimes, it can be too arduous to keep up with new relationships acquired from field research.

Coffey (1999) says that it is rare for ethnographers to leave the field totally unaffected, and the literature only engages on the researcher and human data within the limited scope of ethical principles, such as harm, informed consent, and voluntary participation. I was not trained on the social process of withdrawal from fieldwork, so it was not expected that key informants and gatekeepers would want to build relationships with the researcher or even remember to ask for me and how I was doing after leaving West Africa. As an early career researcher, it can be daunting on how to navigate these relationships that are personal for professional purposes and there should be some space to discuss this outside the ethical framework. "This is less about the contamination of the field by the researcher than about the ways in which fieldwork relies upon the interactions, relations and situatedness of the researcher and the researched." (Coffey, 1999, p. 7).

Stebbins (1991) argues that researchers do not ever leave the field. While one may physically pack a suitcase and depart from the area, many researchers still stay engaged with their subjects and gatekeepers long after data collection ends. Taylor (1991) also writes that he continues active engagement with his research through political and policy discussions, and thus, continues the relationships with his informants, who are part of a marginalized or vulnerable community. He argues that as researchers, we develop a moral obligation to our participants to not disengage our relationships, especially after we encouraged them to get close to us. Continuing relationships can also bring new insights or clarify something, long after data collection is completed. In this respect, the researcher never completely leaves the field.

3.4.7.1 Building and then Disengaging the Relationships

My network in West Africa was complex, as I was based in the capital city areas in both countries, but traveled extensively into the rural interiors, to places where hotels were nearly nonexistent. I often stayed in people's homes, usually a friend or a distant relative of my companion or field supervisor. As mentioned before, there were multiple gatekeepers to access key informants and some of these relationships were intentional, meaning I wanted to meet this person and get to know him or her, so I can speak with informants. Other times, it was by happenstance, such as arriving at the car lot in the town of Gbarnga, Liberia, only to have missed the last taxi of the day heading north to Lofa County. I, therefore, had to hitch a ride in a private vehicle with an NGO worker, who so happened to work extensively with health centers in that community. We got to know each other well over that 12-hour trip and even in the weeks after returning to Monrovia, Liberia. Some informants texted me and asked if I would return to their village again or would call me while I was in the country. However, it did not feel final until a day or two before leaving for the airport, when I contacted them to say goodbye. At the time, I felt that I was completing my professional obligations but later, I realized that I had lost something more personal.

Consequently, the experience of disengaging from field relationships and the fieldwork took several weeks to process. On the one hand, there is excitement and enthusiasm about exploring and analyzing the data and the many possible contributions to knowledge. Fieldwork also shaped a new perspective as many of the important topics raised by key informants had not been covered by the literature review conducted beforehand. On

a personal note, it changed my worldview, as I understood that not everything different was wrong and things that were the same were not always right. I also made friendships that I still engage with, although I have not been able to stay engaged with all the people I met in West Africa.

3.5 Ethics

Ethics approval was granted by the University of Westminster in November 2016 for the fieldwork, and subsequently, an amendment was made and approved in May 2017, the application numbers are ETH1617-0176 and ETH1617-1450. The university has authority over all research ethics across the three major colleges. A risk assessment and overseas travel forms were submitted along with the standard ethics application.

Two events were not initially accounted for and that was the possibility of access to community stakeholders, such as NGO workers, village elders, chiefs, and a *Sande* society leader. A separate data tool was created as these informants may not have known about the specific procedures of a health center. The second incident was falling ill for a few weeks, and thus, falling behind on transcribing the interviews and writing draft chapters. For both these incidences, I requested an amended ethics application.

All potential informants were introduced with the following information: full name of the researcher and interpreter (if needed), affiliation with the University of Westminster, and contact information for the researcher and supervisor at the university. Each person was asked if she or he would voluntarily participate as an informant. Each person was shown a participant information sheet that had full contact details, nature of the project, and their rights as a confidential informant. This included the right to participate or opt-out during the interview at any time without penalty. The details of the information sheet were verbally discussed with each informant beforehand and given to him or her to read. Each person was asked if they had any questions before starting the interview. Those who agreed kept this information sheet and signed a consent form, the consent forms were kept under lock and key. All those who agreed to be interviewed were asked if he or she felt comfortable speaking in English or wanted a translator. For those with limited English proficiency, the gatekeepers who were familiar with the questionnaire were available to interpret. Copies of the information sheet and consent form used are in Appendix B. These

forms were developed using templates from a research ethics guidebook (Kruger, Ndebele, and Horn, 2014).

All informants were over the age of 18 and were able to provide informed consent for him or herself to participate in this study. All interviews used for this study were audio recorded, no video footage nor pictures of the informants were taken. However, audio files will not be available for request, only the written transcriptions.

A summary of the findings will be sent to gatekeepers for distribution.

3.5.1 Data Security

All interviews were audio recorded with a recording device that encoded AES 256-bit level encryption for data security, in case the recorder was lost or stolen. Each audio file and corresponding written transcript were anonymized with an eight-digit alphanumeric code. Each written transcript was also encrypted using the 2016 Microsoft Word encryption feature and stored on a password-protected laptop. In addition, there are back-up copies of the transcripts on the university's secure cloud drive. This provides a double level security feature, as someone would need a password to access the laptop and then would have to know the separate passwords to access the written transcripts. Audio files were held for the duration of the Ph.D. project.

The audio recorder came with software to play the recordings on a laptop or computer to help with transcribing. A local university student was hired and trained to transcribe the interviews into Microsoft word on the laptop. I listened to each audio recording, whether transcribed by the student or me. Written transcripts were kept as close to word-to-word as possible, and only in some cases were texts in brackets inserted for clarification. All interviews had been transcribed, imported, and analyzed at the time of writing this chapter. The data were imported into the Nvivo software for coding and thematic analysis. The coding and analysis is described in section 3.6.

3.5.2 I, the Researcher

As much as we may not want to admit it, every researcher has biases and the best way to conduct scientific research, especially when involving human subjects, is to be aware of these biases and address them.

3.5.2.1 My Preconceptions

I grew up in New York City to immigrant parents who had lived in poverty, under a dictator and his special paramilitary force, the *Tonton Makout*, where people would disappear.⁹⁰ My upbringing was very different from my parents and my experiences visiting a developing country had been limited to recreational excursions in the Caribbean and Mexico. This research was the first time that I stayed long-term in a regular home in a post-conflict country.

In terms of preconceptions, before leaving the United States there were a few. I was concerned that no one would want to speak with me or take time to ‘participate in a research study.’ I equated myself to those annoying 1-800 telemarketers who called to ask everything from what you are eating to your credit card number. I was concerned about safety and understood that law enforcement was weak in these countries. However, one significant preconception that I had was that I would arrive and find everything failing: a weak healthcare system, failing development, failing democracy...etc. I believe this was connected to the literature review that was conducted beforehand, which focused on negative attributes of development. Most of what I read had a very critical stance of progress, and as mentioned, a critical interpretation of performance-based indicators that were used to demonstrate progress. My original research approach was to examine and understand more about the weaknesses and possibly what failed in the response. It was after arriving at my research destination, that these preconceptions changed.

I was hoping for the best but prepared for a worst-case scenario. However, after my first day in Freetown, I was already wandering outside the compounds of my temporary home. A couple of weeks later, I was trying to interact as much as possible with my neighbors. Informal conversations about the research gave deep insights from those affected by EVD. Many people were open and interested in the thesis and more willing to engage in contextual discussions regarding their perceptions and experiences.

3.5.2.2 Working with Informants

⁹⁰ President François ‘Papa Doc’ Duvalier was elected in 1957 in Haiti and there was an attempted coup in 1958. He stopped trusting his army and law enforcement agencies and became increasingly totalitarian. In 1959, he started his personal police force called, *cagouards*, but they were soon nicknamed *Tonton Makouts* after people started disappearing. They were named after a folklore boogeyman that abducts children. See Chochotte (2017), Derris (1976), and Sprague (2012).

Questions on the data tools were broad and exploratory to elicit long narrative responses. I kept the language as simple and plain as possible and showed the data tool to field supervisors and gatekeepers for any minor suggestions on language and style. For example, for the term 'human resources,' I instead said, 'man power' or 'staff.' As these are more commonly used in the local dialects. This will also appear in the text in the next chapter. Also, because of my accent, some words like 'law' had to be spelled out during the interviews, and the word, 'governance' had to be explained as, 'decision making and accountability,' especially since 'governance' sounds close to the word, 'government.'

The criteria were well-defined and inclusive, especially since I had someone to interpret and guide me around the provinces. I spoke to people whom I may not have felt comfortable approaching on my own. In Sierra Leone, significantly more male informants participated than female informants, this may partly be explained by access since more tertiary facilities (hospitals) were visited there. However, I did not consciously factor gender when I was selecting informants in the field, given the high constraints of medical personnel.

However, this is not to say that the gender of the informants was irrelevant, but I had to expand the definition of health workers, just to make sure that I could speak with enough informants in each area. I observed that men (in both countries) tended to work in the laboratories and pharmacies, and I did not interview any female doctor, although they do exist. When it came to visiting health workers in the administrative offices of the county or district health offices, these were overwhelmingly male. The places visited, and health centers targeted, could reflect the gender stratification of the local society.

In the words of James Ferguson (2006, pp.33-34):

[T]hat a culturalized and relativized notion of modernity tends to allow the material and social inequalities that have long been at the heart of African aspirations to modernity to drop out of the picture. In their eagerness to treat African people as (cultural) equals, Western anthropologists have sometimes too easily sidestepped the harder discussion about the economic *inequalities* and disillusionments that threaten to make any such equality a merely ideal or sentimental one.

In other words, these societies have always had inequality, discrimination, and injustice before and after the colonial periods. Modernizing or westernizing will not fix this, as it has not fixed this in Western countries. I care about development, but sometimes it is easy to overlook the inequalities that are already inside the culture and not address them directly. I try to include these factors in my interpretations.

The communities reflect the urban/rural divide and the challenges that come with this. Informants living in an urban environment, with access to amenities and opportunities, have biases regarding those who live in the rural parts or ‘the bush.’ Likewise, those in rural areas have preconceptions of life and expectations in the urban towns. In addition, there are aspects of local politics that I try to address in the interpretations. Speaking with health workers, village elders, chiefs’ council members, appointed officials, NGO representatives, researchers, and community organizers presented a multitude of views, which I hope, provide a balanced perspective of local voices.

3.5.2.3 Reflections as a Researcher on the Data

The narratives from the informants were personal, deep, and sometimes the informants were vulnerable when discussing tragic events, and for some, this included the civil war. These emotions can impact the data and the interpretations for any interviewer. However, the data were sourced from different locations and a variety of local actors for reliability. If I received inaccurate or false information from an informant, this helped mitigate the impact during the interpretation of findings.

I believe the interviews conducted with the informants are reliable in that they are, whom they said they were; and gave honest answers to the best of their abilities. Some health workers were young and had only been in the system for a few years, while others had provided decades of service. They were from urban and rural areas, some believed themselves to have a more sophisticated view or knowledge on these matters, and others felt more comfortable talking about their own experiences. Some had traveled abroad to participate in training and others felt they may never build on what they learned. This is what makes qualitative research so much richer and deep; the questions of society, politics, and development are complex and multifaceted, and the approach to studying it must be equally as comprehensive.

3.6 Data Analysis

This section discusses the processing and analysis of data, such as coding, interpretation, and triangulation.

3.6.1 Coding in Nvivo

The software used was Nvivo Plus version 11 for coding and analysis. Two projects were created, one for the Sierra Leonean interviews and one for the Liberian interviews. There are two levels of coding in Nvivo, the first is a 'node' and that is used for identifying and classifying key concepts in the transcript. These nodes were used to create any themes that will be discussed in the next chapter. Each node was created and defined by me in the following list below. The last nodes that are marked with an asterisk are specific to the Liberian sources, as these concepts were only mentioned by the Liberian informants.⁹¹

In Nvivo, the nodes were manually written and defined, as opposed to the software's word query function. Five nodes were created and defined when working on the Sierra Leonean interviews first, these are listed below:

- Aid Resources
- Bylaws
- Information Failure
- Social Cost
- State Institutional Failures

The search function was used to find texts that can be coded with one or more nodes. For example, to code for 'Bylaws,' searches for 'law' and 'chief' were performed, and I visually scanned through the results and coded the relevant texts. For 'Aid Resources,' searches for: 'aid,' 'NGO,' 'partner,' and 'donor' were performed, and relevant texts were coded. For the node, 'State Institutional Failures,' searches for 'Government' or 'Ministry' were performed. 'Information Failure' was coded by looking for the words: 'trust,' 'information,' 'sensitization,' 'news,' and 'lies.' 'Social Cost' was coded by searching words and phrases like, 'fight the disease,' 'spread,' 'believe,' 'trust,' 'died,' and 'won.' The in-text search function was set to 'With synonyms' so more generalized results could be produced and therefore creating larger search results.

After doing this for the Sierra Leone project, it was repeated for the Liberian interviews, however, with different results - as three new nodes were created. 'TLIs Not Involved' referred to traditional leaders not being involved in the response and this appeared once. 'Community Organizing' and 'Top-Down' nodes were also created. These nodes were then introduced to the Sierra Leone project, and only results for 'Top-Down'

⁹¹ There are some concepts that were found in one case country, but not mentioned in another. Thus, while this marks interesting differences between the two countries, it is not how all health workers or stakeholders feel.

were produced and coded. Thus, TLIs Not Involved* and Community Organizing* were nodes that were unique to the Liberian sources.

After achieving these preliminary findings and having discussed it with my supervisor, I was encouraged to return to the data and find out why there may have been problems with trust during the outbreak. Subsequently, two more nodes were created and searched for in both Nvivo projects: 'Prior Mistrust' and 'Prior Trust.' These were coded after searching for these words: 'trust,' 'mistrust,' 'belief,' 'come to,' 'visit,' 'seek' and 'prior.' However, the queries did not produce many results as it was difficult to determine trust semantically but may sometimes be perceived in the themes. In other words, very few informants discussed trust issues explicitly, however, one may see this concept broadly in the narratives. Another reason for trust-related nodes not to appear often in the transcripts is because the original framework and research question did not explore trust issues critically. It was not brought up by informants as an issue to probe further, except in these few instances. I also returned to the data again to add 'Fear' as a node and this revealed several results.

Most appeared nodes:

- Bylaws
- Aid Resources
- Information Failure
- Social Costs
- State Institutional Failure
- Fear

Least appeared nodes:

- Community Organizing*
- Top-Down
- Prior Mistrust
- Prior Trust
- TLIs Not Involved*

3.6.1.1 Definitions of the Nodes

Aid Resources:

Financial, in-kind resources, human resources, or capacity-building, supplied through external partners and donor countries.

Bylaws:

Legal and codified rules passed by paramount chiefs in his or her respective jurisdiction (chiefdom).

Community Organizing*:

Community members working to maintain order and stop the spread of EVD during the outbreak, this does not entail legal rulemaking.

Fear:

Informants stating that they were afraid to perform in their role or the perception of fear in the community.

Information Failure:

This is when consumers (community members) received misinformation about the health centers or the extent of the Ebola epidemic. This includes rumors or information that they were told or heard.

Prior Mistrust:

This is when informants state that community members did not trust the formal health facilities or health workers before the 2014 Ebola epidemic.

Prior Trust:

This is when informants state that community members trusted the formal health facilities or health workers before the 2014 Ebola epidemic.

Social Cost:

This is a behavior or action of an individual that comes at a personal cost and a cost for someone else, in this case, putting another person at risk for EVD. This includes the undertaking of dead bodies, burials, long-distance traveling, violating isolation, close contact without personal protective equipment (PPE), caring for sick relatives at home without protective material, or healthcare providers not working.

State Institutional Failure:

Defined as a situation where government institutions fail to deliver services or respond effectively to challenges.

TLIs Not Involved*:

Traditional leaders were not involved in the decision making or community engagement efforts during the 2014 Ebola epidemic.

Top-Down:

This is defined as when an informant says that most of the decision making and/or rulemaking came from the top (central government) and down to them.

3.6.2 Thematic Analysis

Thematic analysis allows data to be used in principal concepts or themes for qualitative research (Vaismoradi, Turunen, and Bondas, 2013). This helps to bring order and structure to the findings that can be objectively interpreted, and it is used across a range of epistemologies (Nowell et al., 2017). Thus, for research projects with large data sets, it helps the researcher (especially novice ones) to create an organized and well-structured report. However, Nowell et al. (2017) say that a disadvantage to this approach is that the researcher cannot make claims about language use and while flexible, it may also lead to a lack of coherence when developing the themes from the data.

Using these nodes, three themes were created to structure and interpret the data: 'Government's Response and Community Reaction,' 'Local Institutional Intervention,' and 'Governing the Outbreak.' However, while the themes are applied to both countries, the nodes that comprise them are different for each case.⁹² The coding corresponded with the quotes from the transcripts, and thus, these reflect positive or negative perceptions, while the themes were created broadly to encompass the responses from individuals and across

⁹² In the Sierra Leone project in Nvivo, the nodes 'State Institutional Failures,' 'Information Failure,' and 'Social Cost' were used for the theme of 'Government's Response and Community Reaction,' while in Liberia, this same theme is derived from the nodes of 'State Institutional Failures,' 'Information Failure,' and 'Top-Down.' For the theme 'Local Institutional Intervention,' the nodes for Sierra Leone were 'Bylaws' and 'Top-Down'. In Liberia, the nodes 'Community Organizing' and 'TLIs not Involved' were used. For the theme 'Governing the Outbreak' in the Sierra Leone project, the nodes used were 'Aid Resources,' 'Bylaws,' 'Fear,' and 'Social Cost.' In the Liberia project the nodes used were 'Aid Resources,' 'Community Organizing,' 'Fear,' 'Information Failure,' and 'Social Cost.'

the sample. Indeed, thematic analysis depicts changes in governing and response from institutions and the community.

The nodes of ‘Prior Mistrust’ and ‘Prior Trust’ were used to give a baseline assessment of the informants’ perceptions regarding the state of the healthcare system since the end of the conflict period. The next chapter gives excerpts, and these are grouped by the themes mentioned.

The subthemes consist of examples drawn from the informants’ interviews and can be used to saturate the themes (Vaismoradi et al., 2016). As demonstrated in table 3.1 below, subthemes were substantiated by direct quotations from the informants.

Table 3.1

| Themes | Subthemes |
|--|---|
| Government’s Response and Community Reaction | Response from the government was ineffective. Information and protocols were confusing. Health workers and community members were afraid. Community members avoided the health centers. |
| Local Institutional Intervention | Conducting Health Education. Stopped Movement. Setting up Checkpoints. Referring sick persons into healthcare. Rulemaking. Reintegration of EVD survivors. |
| Governing the Outbreak | Aid Resources supplied clinical resources. How international responders related to the communities. Community intervention helped in disease eradication. |

3.6.3 Triangulation

Triangulation is a strategy that consists of a multimethod approach to collecting data (Denzin, 2007; Denzin, 2012). For example, both quantitative and qualitative data can make the findings more rigorous. Or, there can be investigator triangulation, where multiple researchers will collect and process the data too. This strategy helps to control for biases of the researchers (Carter et al., 2014). Data source triangulation is a method of collecting data from different types of people from different communities (Carter et al., 2014).

However, Denzin and Lincoln (2005; 2008) argue that qualitative research is already multi-method, but triangulation can be seen as an alternative to validation. As explained

above, qualitative research consists of empirical materials, such as artifacts, texts, observations, interactions...etc. In other words, this strategy is adopted as a way of gaining an in-depth understanding of the phenomenon and not as an attempt to validate one objective reality, “triangulation is the simultaneous display of multiple, refracted realities,” (Denzin and Lincoln, 2008, p. 8), and thus, can be used to bring these realities together and show a broader picture.

The epidemiology data from the WHO’s Ebola situation report on the outbreak were triangulated with the primary data, all of which are discussed in the next chapter.

Triangulating the primary data helps control for inaccurate or false information, as responses are sourced between health workers and community stakeholders in different locations and facilities. The quantitative secondary data can draw broad comparisons between the case studies.

3.7 Rigor and Robustness

In all research, whether qualitative or quantitative, it is useless unless the data are valid and reliable. However, how we determine the robustness of the data is markedly different in qualitative and quantitative methodology.

Quantitative research focuses on the breadth, meaning one gathers a large data set that covers many variables and the findings or conclusions from the sample can be generalized to the population at large. In contrast, qualitative research identifies a single phenomenon and gains a deep and close-up point of view (Thomas and Magilvy, 2011). The ‘validity’ of the research depends on the application of the methods and the precision with which the findings reflect the data. ‘Reliability’ describes the consistency of analytical procedures (Noble and Smith, 2015). However, Noble and Smith (2015) say that for new researchers in qualitative methods, it can be difficult to establish these as there are no accepted standards to which the research can be evaluated. Thus, they draw on Lincoln and Guba (1985)⁹³ to offer some alternative terminology and concepts to evaluate qualitative research.

⁹³ Lincoln and Guba (1985)’s *Naturalistic Inquiry* has been cited in the literature on evaluating qualitative research. However, the original terminologies and definitions have been updated and refined over the years, hence the preferred use of these verification strategies for this thesis.

3.7.1 Evaluative Terminologies in Qualitative Research

'Truth value' replaces 'validity,' in that multiple realities exist, and the researcher outlines his or her personal experiences and viewpoints (in a reflexive section, under 3.5.2) and accurately presents the participants' perspectives. Thomas and Magilvy (2011) refer to this as 'credibility,' and that the data set should reflect the human experience that would be recognized by other people who also shared that experience.

'Consistency,' according to Noble and Smith (2015), relates to the trustworthiness of the methods undertaken and the researcher leaving a decision trail, or sometimes called, 'transparency.' Golafshani (2003) also refers to this as 'dependability,' which examines the process and product of research for consistency. This is supposed to mirror 'reliability' in quantitative research and account for personal and research method biases.

'Applicability' considers whether the findings can be applied to other contexts, settings, or groups (Noble and Smith, 2015). Thomas and Magilvy (2011) refer to this as 'transferability' and give the example of a study that was first performed on African American women then repeated on Hispanic women with similar results.

Next is 'confirmability' or 'neutrality,' which is when 'truth-value,' 'consistency,' and 'applicability' have been addressed. Noble and Smith (2015) say this is based on acknowledging complex relationships with the participants and how the undertaking of the research is grounded on the researcher's philosophical position and perspective. Thomas and Magilvy (2011) say 'confirmability' mirrors 'objectivity' in quantitative research. This is where the researcher makes a conscious effort to follow and not lead interviews and is reflective during the data collection and not only afterward.

However, Morse et al. (2002) say that the focus on evaluating research at the end, and not during the process, risks missing serious threats to its rigor until it is too late to correct them. Likewise, some post-hoc evaluations do not really lend credibility or trustworthiness to the findings such as member checking.⁹⁴ Morse et al. (2002) say that most of the time, "with the exception of case study research and some narrative inquiry, study results have been synthesized, decontextualized, and abstracted from (and across)

⁹⁴ 'Member checking' is when interpretations of the data or findings are returned to the informants to see if these are recognized as accurate representations of their experiences (Thomas and Magilvy, 2011). Gatekeepers, who were not interviewed but shared the experiences of the Ebola outbreak, gave their feedback on the findings. the feedback is in Appendix C.

individual participants, so there is no reason for individuals to be able to recognize themselves or their particular experiences (Morse, 1998; Sandelowski, 1993).” (Morse et al., 2002, p. 16). However, all the authors agree that within qualitative research, rigor and robustness rely on the responsiveness of the investigator, and the lack of responsiveness is the greatest hidden threat.

Nonetheless, findings were sent for member checking to gatekeepers in Liberia and Sierra Leone, as this is still one of the more common ways to verify the accuracy of interpretations. However, for the rest of this section, the verification strategies used in Morse et al. (2002) during the research are discussed.

3.7.2 Methodological Coherence

This ensures congruence between the research question and the methods used to conduct the research (Morse et al., 2002). The research aims to understand the parallels and differences between the two countries during a specific phenomenon. Since this research is regarding an in-depth study of a single event and context, qualitative methods and a comparative case study design were chosen to achieve the research aim. There is no hypothesis or theory testing in this project; however, the findings should lead us to a better understanding of the phenomenon and theoretical implications. There is a coherent strategy in choosing these methods to research this event.

3.7.3 Sampling and Saturation

As explained in section 3.4.6, sampling was expanded during the fieldwork to achieve a deeper insight into the phenomenon in question. Another data tool was created to interview community stakeholders. Saturation occurred when there was replication in the categories and themes across all informants. Morse et al. (2002) say that new investigators commonly believe that data saturation occurs when the same participants are interviewed multiple times until nothing new presents itself, as opposed to expanding the sampling pool to include different people. Therefore, geographic and demographics expansion during fieldwork helped to saturate the data. The sampling pool also includes negative cases, where informants did not share the experiences along the themes interpreted, such as the

involvement of traditional leaders during the response or the benefiting from aid resources. Including this in the data analysis helped to provide a more robust explanation.

3.7.4 Data Analysis

Data collection and analysis were not conducted in a linear way, but concurrently. Preliminary analysis and categorization happened in the field during the data collection. Interviews were replayed and transcribed usually within days after collection, for reflection and theoretical thinking to generate new ideas. This helped me to probe questions better and elicit longer and clearer responses. In addition, new literature was reviewed whilst in the field, to try and connect macro and micro perspectives in an attempt to develop the theoretical framework. And, as mentioned earlier, I abandoned this framework after realizing it did not fit with the data nor help to understand and explain the phenomenon.

3.7.5 Theory Development

The theoretical framework was developed as an outcome of the data and research processes, and this can be used for further studies of institutions. According to Morse et al. (2002), valid theories are developed, informed, comprehensive, logical, and consistent. Arguments are sophisticated in a way that these are “complex yet elegant, focused yet profound, surprising yet obvious.” (Morse et al., 2002, p. 19).

Developing the theory was not linear and required responsiveness from the investigator, such as redesigning the research questions, framework, and re-analyzing the data for more insight. Studying a social phenomenon that is as complex as the humans involved, the arguments in this thesis encompass many factors – historical and contemporary, to arrive at its conclusions while maintaining the focus on how and why institutions performed in particular ways. The findings were initially surprising, but with a comprehensive understanding of historical, social, economic, and political factors, the results began to make sense when we examined how the course of action unfolded.

Morse et al. (2002) argue that, when combined, the strategies discussed above build the validity and reliability of the research and ensure rigor of the qualitative inquiry. This is because the research will go beyond just ‘answering the question’ and provide evidence that contributes to our knowledge.

3.7.6 Member Checking

As mentioned above, member checking is still a common evaluative tool, performed towards the end of qualitative research. The Liberian findings and interpretations were sent to a person in Liberia for feedback. Likewise, the Sierra Leonean findings and interpretations were sent to a person in Sierra Leone. The feedback from member checkers regarding data interpretations and how each person was able to see his or her experiences in these findings, are in Appendix C.

3.8 Dissemination of Findings

Findings will be distributed in literary and academic publications and related events. The major publication will be this Ph.D. thesis at the University of Westminster. Sections of the thesis will be adapted and submitted as at least one to two research papers. Findings will also be distributed at a major conference either in Europe or the United States at least once. Additionally, a feedback document will also be prepared and sent to gatekeepers in Liberia and Sierra Leone.

3.9 Limitations of the Research

Generally, there are limitations when interviewing people. Human beings have an imperfect memory; sometimes there are communication barriers, lack of knowledge, or people may give inaccurate information (Low, 2013). While control measures were put in place to minimize such occurrences (such as the size of the study, the availability of an interpreter, the use of open-ended questions to field narratives as opposed to positivistic or absolute responses), it is not unusual for problems to occur during interviews.

Another limitation is the bias of the researcher in selecting the informants and the interview format, hence the choice of a semi-structured format. Each informant was asked the same question, however, since these were broad questions there was also room to probe, or for the informant to elaborate or sidetrack a little. An unstructured format could have led to different informants having different guiding questions. The answers of the informants are presented, nearly verbatim, with only minor edits for punctuations and verb agreement. Readers are therefore able to see the informants' full intent and meaning.

Religious leaders were not interviewed as community stakeholders, so, this thesis does not analyze the perspective of how religious beliefs and customs contributed to perceptions and behaviors during the EVD outbreak, as there is much research and reporting on the role of religious beliefs or superstition during the outbreak.⁹⁵ While some informants mentioned religion as a factor, these concepts were not discussed at length, and, as such, not fully explored in this thesis. However, the lack of religious explanations in this analysis should not be taken to mean that it did not play a role at all. Furthermore, community members who had a role solely as ‘service users,’ without a role in assisting or volunteering during the outbreak, were not included. The research is focused on the governance of the outbreak specifically and the health system generally, thus it sought key informants who would give micro- and high-level details on health governance. However, broadly, the community stakeholders who were interviewed were people who lived and worked in the communities and were indeed service users too. The questionnaire included questions on their perceptions of service usage.

Gender is not analyzed in this thesis, however, that does not mean it was not a factor in the governance or outcome of the 2014 EVD epidemic. In general, there have been multiple studies that have analyzed how health policies and disparities affect women (Doyal, 1995; Gupta et al., 2019; Manandhar et al., 2018). In addition, there have also been studies that use gender analysis to further understand the impacts of this epidemic (Davies and Bennett, 2016; Harman, 2016; Nkangu, Olatunde, and Yaya, 2017; UN Women, 2014).

Two concepts were discussed in the literature broadly, however, are not fully analyzed in the findings: democracy and culture. The literature review relied on many anthropological sources, which often uses a theoretical and analytical approach of cultural relativity to explain attitudes, behaviors, and perceptions of local communities. The thesis includes these cultural perceptions in its analysis but does not explain how culture alone impacts behaviors and norms, only that it can. It includes other explanations, such as political, economic, historical, and environmental factors to give a holistic view of how these different factors could have shaped decision making.

⁹⁵ See Davies, Bowley, and Roper (2015), Grundy (2014), Richards and Mokuwa (2014), and Richards et al. (2015) for further reading. Richards and Mokuwa (2014) and Richards et al. (2015) discuss the significance of religious and cultural barriers that hampered eradication of EVD. Davies, Bowley, and Roper (2015) and Grundy (2014) discuss introducing biomedical information to change behaviors and overcome religious beliefs. Bullard (2018) is a day-by-day account from various news sources where religious and ‘exotic’ practices were reported throughout the outbreak period.

The literature that informs the theoretical framework discusses democratic reforms and democracy in a limited scope (Adjei, Busia, and Bob-Milliar, 2017; Baldwin, 2015; Casey, Glennerster, and Miguel, 2012; North, 2013; North et al., 2015; Tokpa and Yengbeh Jr., 2012; Unsworth, 2010; World Bank, 2002), such as the provision of public goods or social and conflict reconciliation. However, this is not the whole concept of democracy as a political theory. Therefore, it brings in other literature that discuss liberal democratic values to explain that these societies in West Africa do not have the same democratic institutions as in Western countries such as human rights, freedom of speech and assembly, and individualism (Carothers, 2002; Harris, 2012; Hellsten and Larbi, 2006; Omotola, 2010; Mustapha, 2016; North et al., 2015). Although TLIs espoused communitarian rights as human rights (Frémont, 2009; Maimela, 2019; Mqoke, 1996); TLIs and state institutions have a history of human rights suppression and gender inequality. However, there are data and literature to show that TLIs are popular and play a role in contemporary African politics and society (Afrobarometer, 2019; Logan, 2013; Ubink, 2008), it does not necessarily mean that constituents do not want these institutions to reform. Research shows that constituents would support reformations of TLIs to be more democratic and accountable (Van den Boogaard, Prichard, and Jibao, 2019). Additionally, there is research to show that just because TLIs have stronger social capital, it may not always bring better development (or democratic) outcomes (Acemoglu, Reed, and Robinson, 2014).

This thesis uses a market approach to explain human behavior. This approach universalizes the decisions of why people cooperate or not, on the assumptions of choice, information, access, and short-term benefits or costs. Thus, the development of the framework mitigates some of these assumptions made such as information or access, and attempts to explain the benefits and costs of cooperation beyond this. However, this generalizes decision making in the 'market segment,' and sometimes this cannot explain all decisions made or why, nor can it be applied to every health worker or health consumer. In keeping with the purposes of qualitative research, this analysis is meant to give readers another understanding of the phenomenon in question.

Due to the scope of the research, this thesis does not explore the full impact of civil conflict on TLIs. However, it refers to studies that have researched this and subsequent institutional changes (Baker, 2007; Baldwin and Mvukiyehe, 2015; Bellows and Miguel, 2009; Sawyer, 2008; Voors and Bulte, 2014); broadly, how communities that experienced

violence perceive the state and participate in local political processes. The research for this thesis did not obtain primary data on the impact of conflict. Further research is needed in this area and on how these institutions evolved during the post-conflict period.

The member checker from Sierra Leone discussed the 2014 census that was supposed to take place (Appendix C). However, it was canceled due to EVD cases in the eastern region of the country. This person suggested that this was a major political upset that contributed to why some community members denied EVD existed in the country. They felt that officials in Freetown, led by the reigning All People's Congress (APC) party, did not want to count districts that predominantly vote for the opposition party. Specifically, it was believed to reduce the population before the elections. This would add another layer of understanding to why some people thought the government was trying to "reduce the population" and is not always a belief of a nefarious attempt at genocide as reported (Mark, 2014). However, the census was not mentioned in any of the full-length transcripts, so it was not included in the findings of this thesis. Sierra Leone has a history of census manipulation for political purposes (Bockarie, 2015); and indeed, this is a topic worthy of future research.

Since the phenomenon of bottom-up rulemaking was only observed in Sierra Leone in this case study, we cannot demonstrate if the findings are applicable to other contexts (Noble and Smith, 2015; Thomas and Magilvy, 2011). Research on the involvement of TLIs in the 2014 EVD outbreak (Guinea and Nigeria) or the 2018 EVD outbreak in the Democratic Republic of Congo would be worthy of future exploration.

A geographic interpretation of community-led engagement was considered and discussed in an earlier draft of this thesis. However, due to word constraints, it was removed for future outputs.

Due to some technical difficulties with the audio recorder, one of the interviews from Sierra Leone was deleted. Consequently, a full-length transcript for this interview is not available; instead, a summary of the discussion is used in the data analysis. Since this interview was interpreted by a gatekeeper, the summary was verified by the interpreter and logged as DS350003.

3.10 Summary

This chapter discussed the strategic design of the research to provide an in-depth analysis of the 2014 Ebola epidemic. A qualitative methodology was chosen as the thesis was exploratory and focusing on a specific phenomenon (Denzin and Lincoln, 2005; Odell, 2001). Quantitative methods would not address the research aims and objectives regarding the mobilization of community leaders and the impact of emergency aid. Liberia and Sierra Leone were selected because these countries were the epicenter of the disease outbreak and share many common historical, social, political, and economic factors (Bøås, 2001; Harris, 2012; Wright et al., 2015).

Sections 3.3 to 3.4 displayed the transparency and decision trail of the research processes from the initial research design through field interviews. This comprised of having to respond to challenges in the field, the theoretical framework, and changed aspects of the project, to develop more robust and rigorous findings. The process included redesigning the research question, redeveloping the theoretical framework, collecting secondary data, and expanding the sampling to include another pool of informants. Expanding the informants' pool provided data saturation (Morse et al., 2002). These changes were implemented to accurately reflect the major themes provided by the informants on the governance of the 2014 EVD outbreak. These findings were abstracted to consider concepts of governance and institutional quality and to extend the theoretical framework.

Fieldwork was conducted following the University of Westminster's ethics regulations. My perceptions and relationships in the field were discussed in a reflexive narrative as part of my ethical obligations to remain transparent and not let my biases contaminate the data. Data analysis was performed using the Nvivo software and themes were derived from various codes. Analyses were conducted several times during fieldwork in order to perform better interviews and afterward, to get more insight from the transcripts to develop the themes.

There are some limitations to the thesis. Human subjects can sometimes be unreliable and there was researcher bias in choosing the interview format and the participants (Low, 2013). In addition, the scope of the research was limited to a case study of a specific event, although, what is limited in scope can be grounds for further research. The approach used to explain human behavior can sometimes generalize and oversimplify complex decision making processes. The intention is to provide another explanation of a complex phenomenon that involved many factors. The theory and its market approach

using supply and demand factors were developed to include social, political, and environmental mechanisms in its explanation, hence, a thick description (Skarbek, 2020).

These processes were undertaken to ensure the most rigorous and robust findings possible; using Morse et al. (2002)'s framework for determining validity and reliability through methodological coherence, sampling and saturation, data analysis, and theory development. These methods demonstrated the responsiveness and reflexivity of the investigator and accurate interpretations of the data on how the 2014 EVD outbreak was governed by local communities. The next chapter presents the findings in a thematic arrangement.

CHAPTER FOUR: Findings

Data analysis related to the social world.⁹⁶ These are the principal outcomes of the investigation.

⁹⁶ See Anderson (2010).

4.1 Introduction

The first theme, 'Government's Response and Community Reaction' reveals perceptions of a generally slow and highly centralized response in the beginning stages. Health workers felt that the government, referring to the central administration in Freetown or Monrovia, had always neglected the health system and the needs of its workers. Thus, improvising with alternative methods to carry on with their work was not unusual. Information disseminated through state channels was also confusing and vague, which led health workers to misdiagnose Ebola patients for another common illness, such as Malaria. However, Malaria is treatable, so when these 'Malaria patients' began dying *en masse*, confidence in the health system eroded and many people stopped coming to the facilities. These information failures led to high social costs (Ebola deaths). The second theme, 'Local Institutional Intervention' discusses how community and traditional leaders began organizing and conducting outreach efforts. The interventions were mostly in response to inept government management to address the crisis. Furthermore, local leaders had witnessed the traumatic deaths of loved ones. However, the response of local institutions varied in Liberia; some areas enacted isolation, while others only conducted health education. In Sierra Leone, chiefdoms passed bylaws that promoted behavior change, such as reporting all sick persons to the health centers and isolation measures. This helped to reduce some social costs. The final theme, 'Governing the Outbreak' depicts how supply and demand factors were addressed through a culmination of aid resources and domestic authorities and leaders. Informants had varying views on the effectiveness of international aid and government resources. However, that depends on whether the informant was a health worker or a community stakeholder assisting in a nonclinical capacity.

The themes give context and nuance about perceptions, behaviors, reactions, and responses to the disease outbreak. This deepens our understanding of how various efforts were coordinated, hampered, or isolated in governing this public health emergency. The quotes are transcribed verbatim and are in the West African dialects of English, as this represents the raw data. Thus, there is very minimal editing such as punctuation and this minimizes bias from the researcher. However, any words added to the transcripts are in brackets [] and there are guiding texts to explain context and meaning.

The chapter begins with a table of the locations visited during fieldwork in 2017 in section 4.2 and demographic statistics of the informants in section 4.3. The following section is a baseline of how informants perceived the healthcare system before the outbreak. After this, each heading depicts a theme, and these are in sequential order to give a narrative of the Ebola epidemic from the beginning. Each heading (theme) is subdivided into Liberia and Sierra Leone, hence making the comparison easier for the reader. These are from sections 4.5 to 4.7. The quotes inserted are to reinforce the thematic message of how these interpretations were derived. The final section contains epidemiological data published by the World Health Organization (WHO) (World Health Organization, 2016a). This supports the perspectives of the informants on how community-led engagement impacted the Ebola case and death rates.

4.2 Interview Locations

These tables summarize how many health facilities were visited during fieldwork in 2017, and whether it was in a rural or urban township in each county or district.

Table 4.1 Liberia:

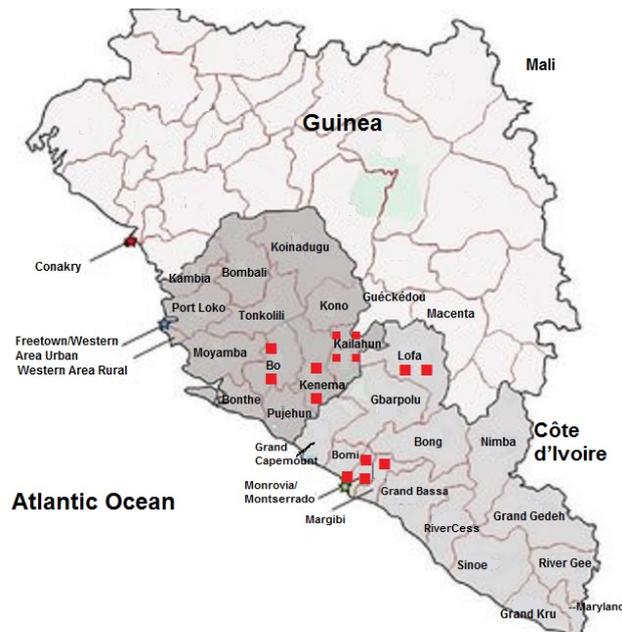
| Counties | Urban Health Facilities | Rural Health Facilities |
|--------------------|--------------------------------|--------------------------------|
| Lofa | Zero | Two |
| Margibi | One | Zero |
| Montserrado | Three (one suburban) | Zero |

Table 4.2 Sierra Leone:

| Districts | Urban Health Facilities | Rural Health Facilities |
|------------------|--------------------------------|--------------------------------|
| Bo | One | One |
| Kailahun | One | Three |
| Kenema | Two | Zero |

Figure 5 is a visual representation of the sites visited during fieldwork in both countries.

Figure 5. Map of sites visited in the field.



4.3 Demographics Statistics

This section contains demographic information of the informants. The empirical findings are based on all sixty-seven interviews that were processed into the Nvivo software for analysis.

There are two levels of coding under Nvivo: the first level consists of descriptive codes that were used to derive the themes. The second level of coding is what Nvivo refers to as 'cases.' Cases are observations made in the field about the person, such as gender, role, or location. These cases are usually self-explanatory and do not have a definition. This level of information is used to provide the summary statistics of the informants. This is summarized in table 4.3 below.

Table 4.3 show case categories of gender, sector, role, and location.

| CASES | SIERRA LEONE | LIBERIA |
|------------------------------|--|--|
| GENDER | Man, Woman | Man, Woman |
| COMMUNITY STAKEHOLDER | Volunteer, Government worker, or NGO representative. Community Leader: ⁹⁷ Any traditional leader or community organizer | Volunteer, Government worker, or NGO representative. Community Leader: Any traditional leader or community organizer |
| HEALTHWORKER | Nurse, doctor, community health worker, midwife, pharmacy worker, or laboratory technician who are formally employed or volunteering in the formal sector. | Nurse, doctor, community health worker, midwife, pharmacy worker, or laboratory technician who are formally employed or volunteering in the formal sector. |
| LOCATION | Bo, Kailahun, and Kenema Districts. | Lofa, Margibi, and Montserrado Counties. |
| NUMBERS | 33 Interviews conducted. | 34 Interviews conducted. |

In total, there were sixty-seven informants, forty-two of them were male and twenty-five were female. As for the community stakeholders, eleven were male and one was female.

In terms of the geography of both countries, thirty-nine informants were in urban settings while twenty-eight were in a rural setting. The urban settings were mainly the urban counties of Margibi and Montserrado, and any headquartered city in a rural district or county.

There are fifty-five healthcare workers in total. Forty of the healthcare workers are classified as a nurse, doctor, nurse aide, or a community health worker. Six informants work in the pharmacy or drug dispensing unit and nine informants work in a laboratory. There is a gender bias for male informants, as traditional leaders are usually male, and there are more interviews with them in Sierra Leone. Laboratory technicians, doctors, and clinical supervisors also tend to be male, and there was more access to laboratory workers and doctors in Sierra Leone than in Liberia. See charts A through C for an overview of informants in both countries.

⁹⁷ For the purposes of the results a separate subcategory of *community leader* is created, so readers will know which demographic of community stakeholders are speaking in the text below. This includes the traditional leaders defined in chapter two and nontraditional leaders, such as a neighborhood taskforce leader.

Chart A: Breakdown of Roles of the Informants

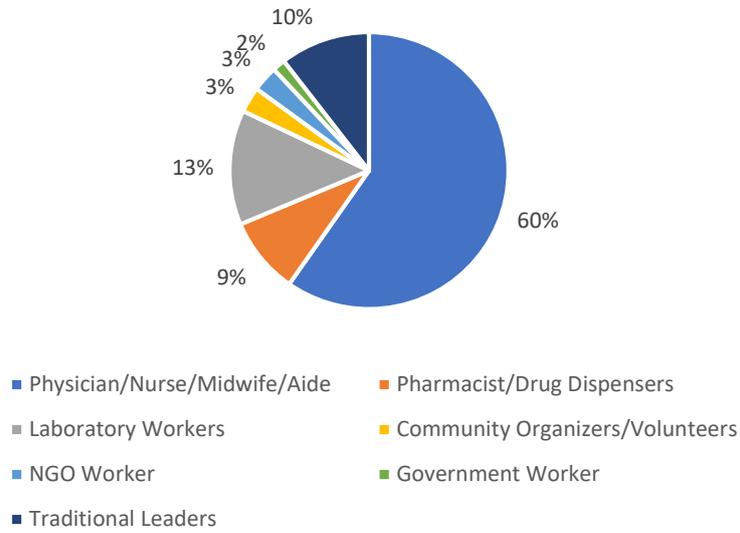


Chart B: Total Informants by Communities

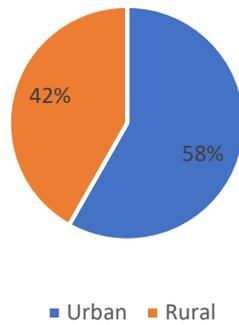
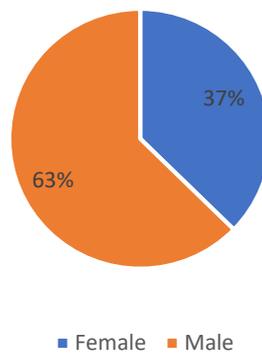
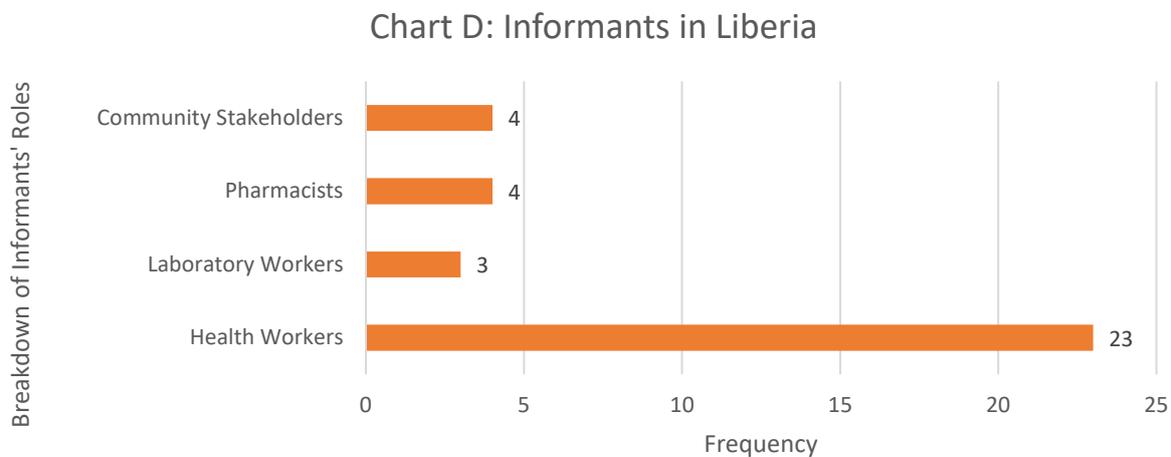


Chart C: Total Informants by Gender



4.3.1 Liberia

Two-thirds of informants interviewed in Liberia were in predominantly urban areas; this is because two out of the three counties are identified as urban (Montserrado) and peri-urban (Margibi). Additionally, in both counties, the interviews happened in cities, such as Paynesville and Monrovia, in Montserrado County. In Lofa County, two rural districts were visited to conduct interviews, then one district in Margibi County, and two districts in Montserrado County. Sites were chosen to include an array of primary, secondary, and tertiary level health facilities.⁹⁸ Because the study is qualitative, data were collected via semi-structured interviews. Thirty-four interviews were conducted; and these were with four community stakeholders and thirty health workers at six health facilities, in three counties. The gender ratio is fairly even, although all community stakeholders and laboratory technicians were men. See chart D for the categories of informants, chart E for the statistic of urban and rural areas, chart F for the gender breakdown of the informants, and chart G for the number of informants per county.



⁹⁸The healthcare sector is divided into multiple levels to deliver comprehensive services. Primary health care and its facilities are the first point of contact, such as a dentist, nurse, pharmacist, or a family doctor. Secondary care and secondary health facilities tend to be specialized services that one would be referred to, such as a cardiologist, ophthalmologist, or an oncologist. Tertiary level care tends to be highly specialized with specialized equipment that requires hospitalization, such as neurosurgery or organ transplant (Multiple Sclerosis Trust, 2018; Torrey, 2019). However, these categories may differ in low-resource settings like Liberia and Sierra Leone. Some primary level facilities receive emergency patients even though, they are not equipped to handle this. I also observed secondary or tertiary level facilities conduct primary health services since there is a lack of these services. For example, ELWA Hospital in Monrovia has recently opened a first come first serve dental clinic.

Chart E: Breakdown of Communities Visited in Liberia

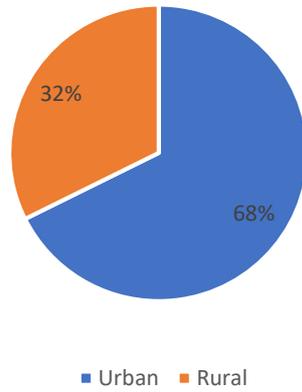


Chart F: Informants by Gender in Liberia

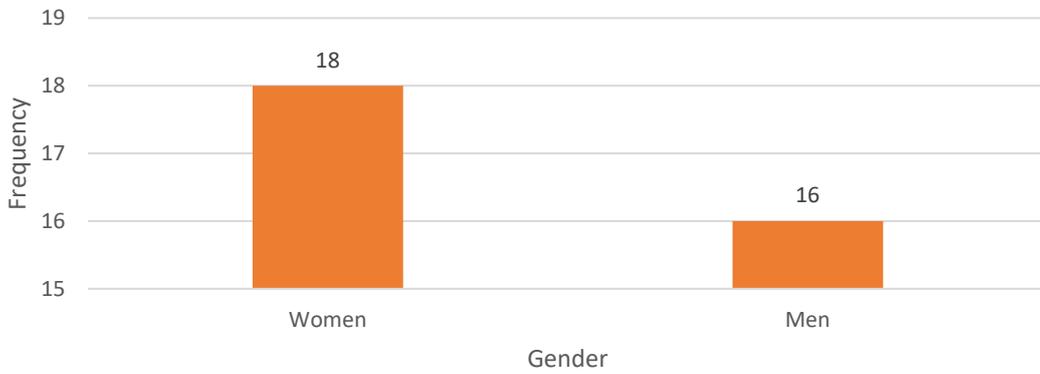
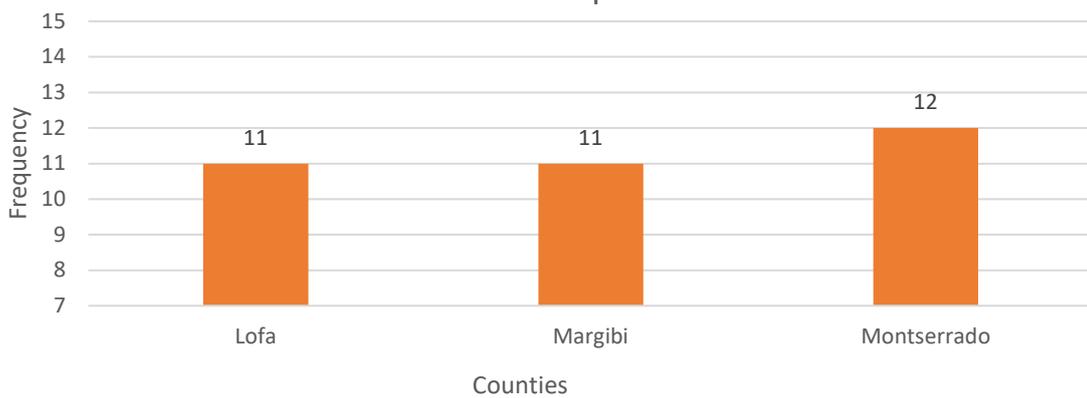


Chart G: Informants per counties in Liberia



Because of the disease path of the Ebola epidemic, informants are primarily in urban-based locations. The next section provides demographic information on Sierra Leonean informants.

4.3.2 Sierra Leone

The demographics summary for Sierra Leone shows a fairly even distribution of informants in rural and urban settings. A total of thirty-three semi-structured interviews were conducted and these were with twenty-six health workers and eight community stakeholders in three districts at a total of eight health facilities. Some hospitals visited in the headquarter cities of the rural districts, like Kenema or Bo Town, are classified as an urban area. In the Kailahun District, four chiefdoms were visited to conduct interviews including the Jawei chiefdom where the bylaws originated. In Kenema, one chiefdom was visited, and in Bo, two chiefdoms were visited. More men than women were interviewed. This is partly due to the larger number of local community stakeholders who form part of the paramount chief's councils are all men and the tendency of men being in supervisory positions in clinical settings. However, a female community stakeholder, identified as the leader of the women's secret society was also interviewed and is the only female community stakeholder in the study. See chart H for the categories of informants, chart I for the statistic of urban and rural areas, chart J for the gender breakdown of the informants, and chart K for the number of informants per district.

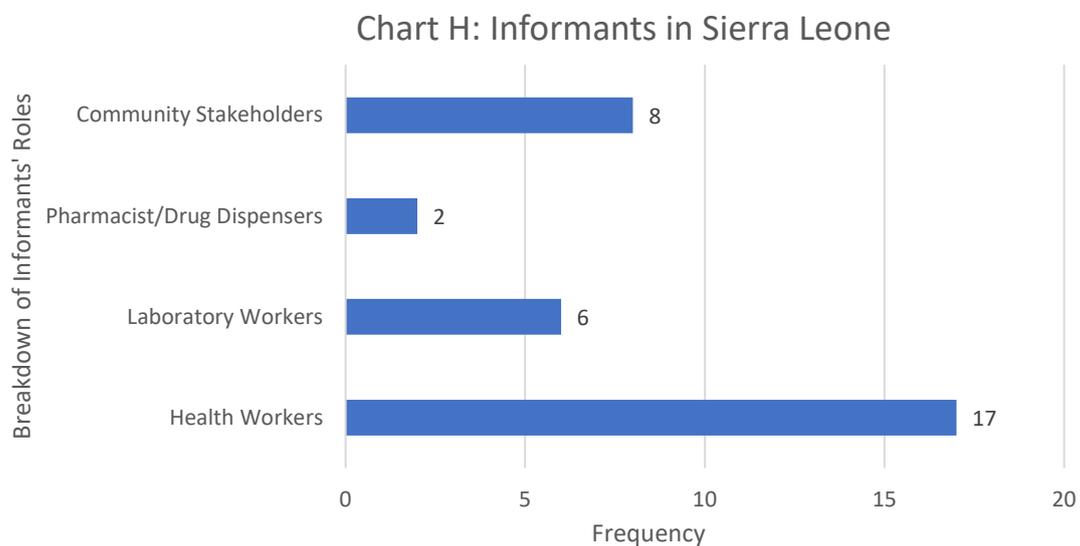


Chart I: Breakdown of Communities Visited in Sierra Leone

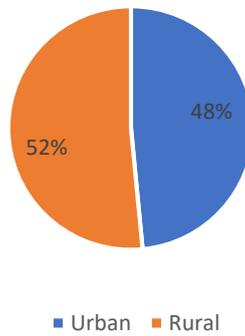


Chart J: Informants by Gender in Sierra Leone

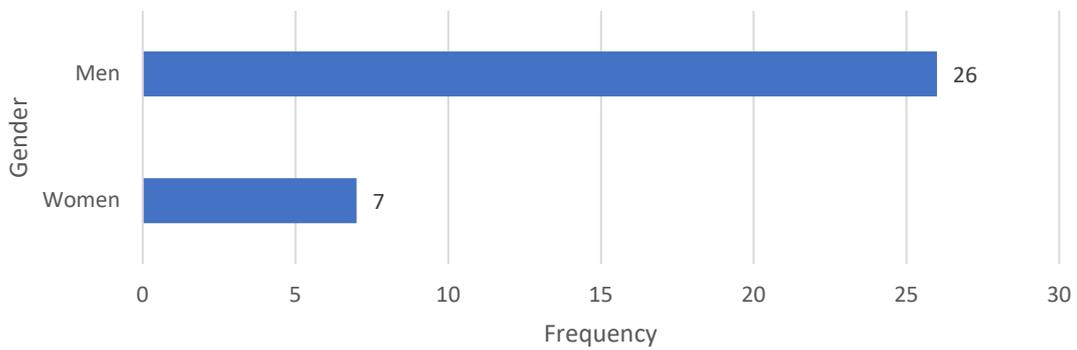
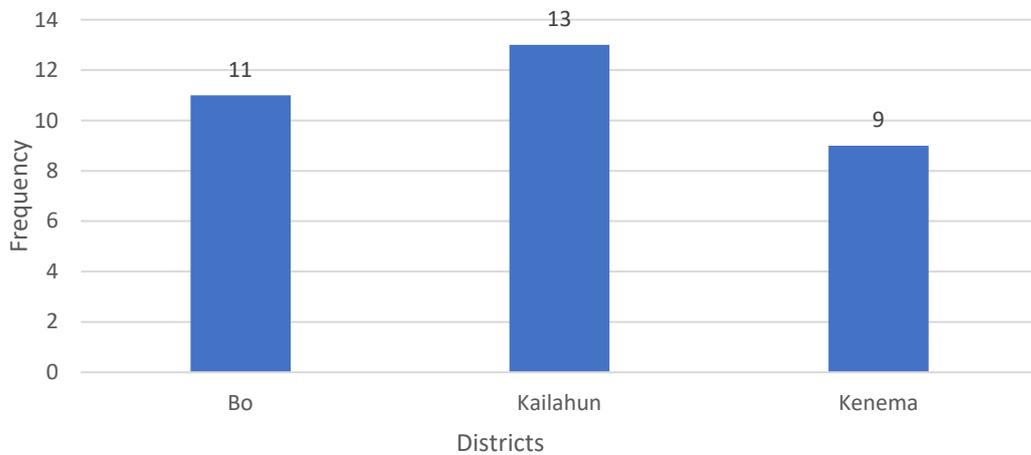


Chart K: Informants per districts in Sierra Leone



Because of the disease path of the Ebola epidemic, informants are primarily in rural-based locations. The next section is a baseline of the health systems before the Ebola

outbreak. This is a point of reference for the thesis as it started with the contextual backgrounds of the case studies in chapter one.

4.4 Baseline Assessment: The State of Healthcare and Confidence in the System

Each country is introduced with a baseline of how informants perceived the healthcare system and usage before the 2014 outbreak. These perceptions touch on the concepts of trust because there was a high level of mistrust in the workers and the healthcare system during the Ebola epidemic. However, issues of trust were not explicitly explored during the interview. Informants only mentioned this, if they felt it was relevant.

4.4.1 Liberia

Before the 2014 Ebola Virus Disease (EVD) outbreak, informants described a healthcare system that was in the process of rebuilding from civil conflict such as training more health workers; hence, the infrastructure has improved since the war. Many informants did not mention if trust from the community was a major barrier before the outbreak since it was not explicitly asked, unless probing. Rather, some felt that the lack of access to the facilities and the lack of biomedical knowledge of illness and the body were factors. However, only two informants mentioned trust issues before the 2014 EVD outbreak. A health worker felt that community members trusted the staff at his facility, but this was only temporarily lost during the epidemic and a community stakeholder had this view:

I think there [has] always been a distrust of government; so that [was] also one of the weaknesses before the Ebola and one of the weaknesses during the Ebola crisis. There's been a distrust of government. If the government says, "There is Ebola," nobody believes the government. It's trust. So, government can come and say, "We're doing this," and everybody will say, "That's not true," there's a mistrust, OK. So, communities do not trust government. Zero. Anything government comes up with, they don't believe it, because they know it never, *never* happens in Liberia. So, because of that, communities are more likely to align with international organizations to be able to accomplish. (Community Stakeholder, Montserrado County)

The informant suggests there is a general mistrust of state institutions and not just the healthcare sector specifically before the EVD outbreak. Therefore, many people did not believe the Ministry of Health and Social Welfare (MHSW) regarding EVD. There was a mistrust of the government and its response to the mysterious conditions happening at the time.

This also means there is a nuance to the concept of ‘believing EVD.’ Many people had biomedical knowledge to understand ‘illness,’ however, not believing there was EVD meant that people did not believe the government accurately assessed and confirmed its presence in Liberia. However, a confirmation from the WHO, Red Cross, or Médecins Sans Frontières (MSF) could have changed this perspective. The informant says that people were more likely to believe an international partner. It is difficult to generalize about the community’s trust levels, as an individual may be trusted, while still having strong reservations about the system.

4.4.2 Sierra Leone

Informants described a healthcare system that was slowly improving and with the right attitude, the country can regain its position in West Africa. It is not uncommon to hear someone recall a time before the war when Ghanaians came to Sierra Leone to line up and buy toothpaste. External partners such as Catholic Charities, Samaritan’s Purse, and nongovernmental organizations (NGOs) have delivered services for many decades. However, before the EVD outbreak, many of the health facilities were in poorer condition than when I visited in 2017. For example, many facilities did not have running water, 24-hour electricity, or a consistent supply of Personal Protective Equipment (PPE). This builds on what was discussed in chapter one as ongoing problems from before the outbreak. The outbreak brought some resources, but it depends on the aid organization and how long each may stay. One person explicitly discussed how community members mistrusted the healthcare system before EVD, and three felt there was prior trust.

Some communities preferred private facilities and others visited both government and private facilities. Also, health workers in the maternity wards described a significant increase of patients and associated this demand in services as trust. The increase in patients had to do with the Free Healthcare Initiative (FHI) passed in 2010 that gave some mothers and all young children free services. So, with user fees removed, there was an increase in the demand for health services.⁹⁹

From their training, college, and their nursing schools, they have not been receiving enough training; so that when they come to the field, people trust them and know what they are doing. I think for quite a while now, it has been losing credibility because people have been accessing the health facilities without being cared for, without having the correct service that they want. So, their needs have not been met. So, there is a lack in trust in the health sector. That was quite evident during

⁹⁹ After the Ebola epidemic in Sierra Leone, EVD survivors were added as eligible participants to the FHI. They are supposed to receive free health services at any state-run health facility.

the outbreak. People did not go to the hospital, because they think they may get the infection in the hospital. (Health Worker, Bo District)

This informant above says something important about prior mistrust and what happened during the outbreak. He says that people did not visit the hospitals because they were afraid of getting infected, due to prior concerns of poor training and quality of care.¹⁰⁰ This provides a different explanation as to why some believed that health workers were ‘injecting’ people with EVD. It may not have always been a fear of nefarious activities, but rather the concerns of nosocomial transmission.¹⁰¹ This is repeated throughout, but it may not always construe that people thought health workers were purposely trying to kill them.

4.5 The Government’s Response and Community Reaction

This theme explores the informants’ perceptions of how the government responded and the community’s reaction during the EVD outbreak. Some of the concerns raised about the domestic response have been ongoing issues before the outbreak and some continued afterward.

4.5.1 Liberia

Health workers expressed frustration with the working conditions, general day-to-day management of the healthcare centers, and the initial EVD response. As mentioned in the first chapter, Liberia is a post-conflict country, where memories of war are still fresh in the society’s psyche. The sight of closed health centers and deaths was a traumatic reminder of a not-too-distant past for Liberians. In the beginning stages of the outbreak, some confusing messages gave conflicting advice to health workers on how they could still perform safely during the outbreak.

Informants reported that one of the initial guidance they received from officials was to avoid physical contact. No touching sick relatives or friends, no touching any dead bodies, and for those practicing medicine, no touching patients without proper PPE like gloves,

¹⁰⁰ Indeed, in past Ebola outbreaks health centers were the source of infection due to contaminated equipment and community members would quickly realize this and avoid visiting these places for any treatment. This is notable in the 1976 Ebola outbreak in the Yambuku Mission Hospital in northern Democratic Republic of Congo (Bremner et al., 1978).

¹⁰¹ Nosocomial infection is also called ‘hospital-acquired infection or healthcare-associated infection’. This is commonly associated with antibiotic-resistant bacteria, such as MRSA, but can be any type of infection acquired in a health facility. This may be due to unclean hands, surfaces, medical equipment like catheters and IVs, or being roomed with a very ill patient. Proper barrier nursing/IPC training and equipment helps to prevent this. See Landers et al. (2010) and World Health Organization (2002) for further reading.

masks, and bodysuits. Many health workers recounted that their health facilities did not have adequate PPE needed to conduct services safely. Therefore, patients who displayed general symptoms such as vomiting were referred to the Ebola Treatment Centers (ETUs). However, it is normal for health facilities to routinely operate without a consistent supply of PPE:

Like, when they supply us, we just have to manage because when it is finished, we will catch a hard time to get it. So, when it is here, when it is available, we have to take our time [in] how we will use it. We don't really use it, like take for example, if you get about, maybe, they just brought about fifty of these gloves. OK [but] now for NCH we can use more gloves. You want to touch patients, you want to do this, you want to do that every now and then [and] we have to change gloves. So, we have to take our time [in] how we really use it, so it can't finish. Because when it finishes, we have difficult time to get another supply. (Health Worker, Montserrado County)

In this response above, the nurse explains how health workers judiciously use the limited resources available, using gloves as an example. They rely on MHSW in Monrovia, to send resources, such as gloves, masks, equipment, and drugs to their facility. However, these shipments often contain small amounts and do not come consistently.

[B]ecause they said there was no supply, so health workers were not attending to patients. So, when they bring in, most people shy away saying, "I'm not going to touch you, because I have no protective clothing." (Health Worker, Montserrado County)

So, every word we say, we get it from the central government. "Say this" because initially there were people who said, "don't touch," [however] "don't touch" brought more death rate. (Community Stakeholder, Margibi County)

These responses above demonstrate the impact of the message to avoid physical contact. In the first quote, the health worker explains that due to the lack of basic PPE and specifically, the specially designed full bodysuits, when handling a biosafety level-4 pathogen like EVD, health workers avoided contact with patients. In the second response, the community stakeholder explains how they disseminated this information, but the 'don't touch' message was impractical because of the weak mobilization of resources; this left little choice for caregivers and healthcare workers.

Another example regarding the government's response was how the burial response teams were only operating out of Monrovia. However, the hotline was quickly overwhelmed by requests that came from across the country. Thus, for families who lived as near as Margibi County or as far as Lofa County, a corpse sitting for days in the home, unattended, was also impractical. The height of the epidemic occurred during the rainy season, where temperatures average 90°F (32°C). In addition, it is uncommon for the average household to have refrigeration, so this would attract many kinds of vermin, rodents, or other scavengers,

leaving families with little choice in the matter. This informant below describes it as a potential health hazard:

So, if the person died and you are calling for the burial team from Monrovia, it will take one to two days before the burial team can come. And that body would be decomposed. So, it is not only Ebola, but it brought other contagious diseases because if the body is decomposed it brought another hazard. (Same Community Stakeholder, Margibi County)

The response was generally characterized as slow and highly centralized in the beginning stages, such as the example with the burial team above. However, even those working in Monrovia said that mobilization from MHSW still took time, especially with contact tracing:

Time. Time to trace the contacts, the Ministry took a lot of time in tracing people. If a person, “Mary”, is in place A and the virus took over place A; she will leave place A to go to place B before the Ministry of Health will get to know about Mary. And to get to Mary will be too late. Time of arrival, time to get the information, there was a break [down] there. (Health Worker, Montserrado County)

Other than information and weak mobilization of resources, another main challenge that health workers discussed had to do with salary and government enrollment. Many health centers in Liberia are co-operated with a donor, NGO, or a faith-based charity, like ELWA Ministries Associations at ELWA hospital in Monrovia. Health workers expressed a preference for working in facilities like these since external partners provide funding to hire staff and other resources, such as medicines, fuel for generators, and clinical supplies. They believe that these facilities are not only better supplied, but workers receive higher pay and consistent paychecks. Informants term this, *incentives*. However, these quotes below demonstrate that this could create an unsustainable situation:

There are efforts to motivate. Say for example, an NGO has a target and their target is to reduce maternal mortality in Nimba County, in a resource-limited area in Nimba. So, they know that [in] the urban area in Nimba, people are most likely to use the referral hospital, so they go and base at the less privilege area in Nimba. So, what they do is, try to recruit and retain staff in order to meet their target; they have to provide an added incentive. Added, in the sense that the government’s incentive is small, but doesn’t come; so, they provide you incentive to retain you there and make you do what you’re supposed to do to meet the target. So that’s what happened. In that case, there is an increased likelihood that these healthcare workers will stay at those sites while those international organizations are there. As soon as it’s abated, meaning the services end and they leave, the financial benefit is cut off and creates, it’s kind of like a revolving door. It’s not sustainable. That’s where I’m going with this, it’s not sustainable and it gets into a vicious cycle. So that’s what we are facing. (Community Stakeholder, Montserrado County)

We only pray that when the year ends the government will be able to sign a new contract with the NGOs; because looking at it, without the NGOs too, the government will not be able to cater to all their health facilities in the country. The government too, needs a helping hand. (Health Worker, Lofa County)

In the health facilities, ‘volunteers or incentive staff,’ means that they are working on flexible contracts provided by an external partner. This includes health workers who are working in the county health offices but are not paid by MHSW. Those who are enrolled and

employed by MHSW earn a low salary (e.g. a nurse makes about \$100 U.S. dollars a month) and are sometimes paid months late.

The problems regarding salaries continued throughout the outbreak and afterward. Liberia's economy reflects the fragility of its healthcare system; prices for household goods are not stable. Thus, while healthcare workers' salaries are fixed, the price for a half bag of rice (25 kilograms), can fluctuate several dollars from week to week. One informant calculated for me during an interview, an exchange rate of L\$110 Liberian dollars to 1 USD on a Thursday can increase to L\$112 or L\$113 at the start of the new week.¹⁰² On its own, L\$2 or L\$3 dollars cannot purchase any goods, but a monthly or biweekly bag of rice that cost L\$ 5,550 (50 USD) could appreciate to L\$5650 overnight. This L\$100 difference would cover commuting costs and/or smaller household purchases like tea, butter, and bread. There were promises of hazard pay for workers risking their lives under these conditions, but sometimes it did not materialize. This, along with the other factors explained above, resulted in some health workers refusing to come to work and some facilities closing:

Yeah, during the outbreak, other health workers decided not to work. They stayed away because Government was not willing to pay health workers at the same time while we were in the situation...They don't want to pay. So, some health workers decided to go back and rest, until the outbreak of that virus can be ceased; until later, when some international NGOs came in to help and giving health workers a little thing [incentives] to keep on working. It is how people started coming in to work and help people. (Health Worker, Margibi County)

As reflected in this quote above, some health workers in Liberia left their facilities until the outbreak slowed or until they heard an announcement on the radio for health practitioners to return to work. Some facilities closed due to a lack of staff to provide care. This was the combined impact of health workers dying and their colleagues became too fearful to stay. One person said that the administrators of her hospital had left, and she acted in-charge until its closure. The cost of health workers staying away from the facilities produced negative externalities for Ebola and non-Ebola patients. In a country with a fragile healthcare system and high maternal-infant mortality rates (MMI), it meant pregnant women, who were about to give birth, had fewer options for safe delivery. Also, those who presented with nonspecific symptoms, such as fever and vomiting, had to travel to a distant ETU only to find out that they did not have Ebola, but not an actual diagnosis.

For me, actually, I left the town and went in the bush for my life because it wasn't easy in the town. The town, their community denied, "effect of Ebola was not there because it was a man-made sickness" according to them. (Health Worker, Lofa County)

¹⁰² This exchange rate of L\$110 has changed since fieldwork. At the time of writing, it was L\$160 to \$1 USD.

But after equipment and other things started coming in, then things started getting alright and the fear started going away. (Health Worker, Montserrat County)

Phase one¹⁰³ was confusing and had slow mobilization from the government and the international community, which led to fear from the health workers and the community members, as reflected in these two quotes above. Some informants said that leadership at the national level improved, such as the introduction of an incident management system and the decentralization of laboratories and ETUs into the rural counties. However, nineteen out of thirty-four informants say that the response was top-down because decisions were made in Monrovia and they were given the directives to implement it. This includes the perspectives from a county superintendent's office and the county health offices.

There were some positive changes, eventually, MHSW began engagements at the facility level to mobilize and inspire health workers. This was a change from a response that was initially centralized and decision makers detached from the reality on the ground, as depicted in this final quote of the theme:

They (MHSW) asked others' views. And then, they told them this is how we can do it, because this had to be a ground thing. You can't just go, only two persons go discuss and you leave. It has to be a concession of everybody in the group, in a group setting. So, they got in contact with other health workers and it helped in the process. (Health Worker, Margibi County)

4.5.2 Sierra Leone

Informants said that the government of Sierra Leone did not effectively respond to the initial cases of EVD in the Kailahun District. The first case was declared in May 2014, but there were suspicious unconfirmed cases since April. State institutional failures did not only happen during the outbreak. It was an expectation that the policies created in Freetown would not be implemented, nor stay in place for long, before everyone did their own thing. The term 'own thing' is a common reference in West Africa, and it may sound dismissive or that someone is being neglectful, but it is not. Rather, it is resounding and determination to get on with the work, even without the proper tools or guidance. The system is highly centralized and thus, decisions such as recruitment, hiring, salary, distribution of medical supplies, are determined in Freetown. Although there are some monitoring and evaluation

¹⁰³ In this thesis 'phase one' refers to the period from December 2013 to September 2014. Phase two refers to the period of October 2014 until the epidemic was declared over in June 2016.

procedures, these are not consistent and often concerns are not addressed in the peripheral districts.

When EVD was detected in Guinea and Liberia, there were no safeguards put in place to protect the porous borders. One informant mentioned that this is how EVD came into Sierra Leone, via a health worker treating patients in a neighboring country:

The response was really late; whether on the part of the Government because of the ignorance. They knew it was in Guinea and Liberia before it came here. Why I am blaming the Government is because when there is war in a neighboring country, you have to be ready, so there will not be a spillover in your own country. There are a lot of crossing borders in this part of the country, people migrate from there to here, and even health workers who are looking for money crossed into Liberia or Guinea to treat and brought Ebola back. A health worker brought Ebola into this country from Guinea into Koindu and Daru, then that was how it spread fast. (Health Worker, Kenema District)

After the first EVD confirmation, there were no allowances made for staff, fuel, and medical supplies needed for the intensive case management of EVD patients. Information focused on staying away from *bushmeat*, however, when more people became sick and not from the *bushmeat*, then fear, rumors, and stigma arose. Health workers also received confusing protocols. Informants said EVD education and posters depicted patients vomiting blood and hemorrhaging from other bodily orifices. However, these symptoms only appeared in a small percentage of cases, if ever. Therefore, when many patients came to a facility with nonspecific flu-like symptoms and not the highly visible and unusual symptoms of hemorrhaging; there were many misdiagnosed cases in the beginning. Thus, many people went into the clinic for a seemingly nonlethal disease, like Malaria, only to not return home. It had raised suspicions and fears that health workers were doing something nefarious or perhaps were incompetent.

It was devastating, in fact the community where I was working was the second chiefdom to be hit. It had started in Koindu, in the Kissi Tong chiefdom and we share a boundary with this chiefdom, so it came to us next. Some of us survived only by the grace of God, because when it came, we played with these patients [touching with no PPE]. Initially, we had an influx of patients with fever, diarrhea, and vomiting and we never knew it was Ebola. We touched them, we touched all their lives, and it was only when a sample was taken from Koindu and [then] taken to the laboratory in Kenema; that was when we heard it was Ebola. And the information came quickly that we should be very careful with the Ebola patients. That was the time when we realized that we are in a deadly situation. So, initially my health facility had seven of them, [but] there wasn't enough space. So, they were lying in the waiting area and doing the little we could. At that time, we did have enough IV fluids and some of them were on it. We had tested them for Malaria, because that is the first thing we do when there is a fever, the rapid testing. We were doing it and some were negative with Malaria, so then we thought it was Cholera, but it wasn't Cholera. So, after admitting those seven, I decided to refer all of them to the Kailahun Government hospital, because this is our point of referral. However, fortunately, one went to Kenema, but the means of transportation is a commercial vehicle [taxi], so it was just too dangerous. She went to Kenema and the initial results that came to us at Kailahun [here at the health center] was Lassa fever, not knowing that at one time this lady had Lassa fever. But when she returned and did the test again, the information came back that it was Ebola. The other six, instead of going to the hospital, went back into the community and all of them died. (Health Worker, Kailahun District)

So, during the outbreak, one of things, the community people were given false information at the time. That is the IEC program, the Information, Education, and Communication program. They printed posters that people may be vomiting blood, blood running from the ears, from the eyes, are suspected Ebola cases. It came to a time now, where people never showed those signs and symptoms, so what happened? The community people said the health workers have failed them,

they have teamed up to kill them, and people lost total confidence in the health system in Sierra Leone. (Health Worker, Kailahun District)

In the first quote above, the health worker describes what happened before the first case was announced. The health workers could only do limited testing, usually for Malaria or HIV, and if those tests are negative, then Cholera is suspected, and the patient is sent home with antibiotics. However, if they are still sick or several cases have similar symptoms, then they will refer them to the main hospital for further evaluations. However, one woman decided to leave the district and go to another hospital, twice. The second time confirmed she had EVD. However, for the remaining patients, they died before receiving their diagnosis.

In the second quote above, another health worker discusses how information about EVD lowered trust in the community, as many EVD patients did not have hemorrhaging and died anyway. Leading to a belief that loved ones did not have EVD (because they did not have the hemorrhaging symptom) and their death was malicious.

This led to the stigma and discrimination of health workers, as described in this quote below:

This Ebola, it is comparable to none, no other outbreaks. In fact, to me, I said this is the worst disaster we have ever encountered on earth. If you see the number of people that were dying, the number of denials, the number of stigmatizations it was too high. There was a time when nurses were not wearing their uniforms, they hide it because if they see you on the street, they will throw stones at you or boo at you. It was worse than ever. If you are working in the Ebola center, they ask you to leave the home. (Community Stakeholder, Kenema District)

Informants said that many people stopped seeking treatment for any condition in the health centers, and rather, treated at home or possibly sought a village healer. Some partly attributed these behaviors to information and state institutional failures, such as the message, "There is no cure." Hospitals in West Africa are viewed in a curative medicine paradigm.¹⁰⁴ If one is going to die from a disease, then why not in the comforts of home, rather than travel great distances and at a cost, to a hospital. So, while there was fear too, it is also possible that given the costs it would have taken to get to an ETU, it may have been seen as fruitless by some. In addition, given the conditions of the health centers and perceptions of quality of care, avoiding them may have been a rational choice to prevent

¹⁰⁴ Curative medicine focuses on treating illnesses and conditions where it is feasible. This differs from preventative health efforts aimed at preventing infections. The latter includes addressing social measures; for instance, improving housing and sanitation to lower Tuberculosis infections in the early 20th century ('Curative and Preventive Medicine', 1937). This was also briefly mentioned in chapter one, section 1.2 as social etiology of health where underlying socioeconomic conditions are evaluated as part the health status, see Kelman (1975), Phelan, Link, and Tehranifar (2010), and Waitzkin (1981) for further reading on the social impacts of health.

nosocomial infection. Every health worker said they did their utmost best to save lives. However, the nosocomial transmission of EVD was a concern to health workers and the community alike. This may not be comforting to those who faced stigma and discrimination during this time, but it gives a deeper understanding of why some people avoided the health centers.

However, one could say that at the start of the outbreak, one of the information that went out created a lot of discrepancy in information, like misinformation. Like saying, “it’s an illness that hasn’t got a cure” and people completed the sentence by saying “then why should I go to the hospital?” If it hasn’t got a cure, then why should I go there? Rather, I stay at home and die...so that was one thing. It was a weakness on the side of the system, which presented reluctance or resistance from the community or masses, [and] made the outbreak worst. (Health Worker, Bo District)

Patients were also not coming to the hospitals because they were suspecting the health workers to have Ebola. The belief was, when you come, they would inject you with it and you die. So, there was that fear. (Community Leader, Bo District)

The second quote may sound as if there was a conspiracy, however, given the context that people knew IPC was poor; this may also refer to the fear of nosocomial transmission and not always because of nefarious activities.

The health workers discussed the working conditions before, during, and after the epidemic. Below in this quote, a health worker says that restrictive movement measures by the government were initially ineffective, due to misinformation and rumors about the mysterious illness and deaths:

So, when the government started to implement some measures to actually contain the disease, politics came in there again. People are thinking that they want to reduce the population, of people in the Kailahun District or some constituencies. So, it was difficult for government to even put restrictions on people moving from the affected zone to the nonaffected zone. So, people who get in contact with those infected people were moving in the country without restrictions. So that [is] why you will see there is that sporadic explosion of cases from all over the country; because someone will get in contact with a patient here, and he will move to another community where people don’t know. (Health Worker, Kailahun District)

Many health workers did not receive any recognition for their service, let alone a regular salary. This was a problem before the epidemic and had not changed during the time of the fieldwork in 2017:

The [NGO name]. They told us that we should not be given any package and when we started hearing that, some people became very annoyed over that. But at the end, you hear some people say that we worked for our country even with or without [it], we can still make it up. So, they virtually left here with no compensation. (Health Worker, Kenema District)

In this quote, I asked about the strengths and weaknesses of governing the outbreak. This person responded that one strength was the many aid organizations that came and recruited people, but she and others thought they would be compensated, but in the end, they were not.

4.6 Local Institutional Intervention

This theme describes how local communities decided to organize to protect themselves from an EVD outbreak or stop EVD from spreading.

4.6.1 Liberia

Some communities conducted collective action against EVD and what they perceived to be an inept government response. However, this did not always happen swiftly or with cooperation in communities. One informant stated that the organization of paramount chiefs and other traditional leaders were uninvolved in the response and ignored sensitization efforts from health workers. The first two quotes say that these local leaders were part of the initial problem of getting the community to believe them, as chiefs were also spreading rumors and misinformation. However, where possible, traditional leaders were incorporated into community engagement efforts as the third through fifth quotes below demonstrate:

So, from the Monrovia level down to the county, they had a cordial relationship. That is, you have the county health officer in the county who reports to the chief medical officer in Monrovia. So, that relationship has been there, but now the issue of trickling down the information from the county to the communities, there was the gap at the time. There was not much community engagement, so the information reaching to the chiefs was difficult, because most people focus on curative instead of preventive medicine. But now that the outbreak came, we also look at more preventive and balance it with the curative services. (Community Stakeholder, Lofa County)

But then, the community leaders were not really involved into it. In addition, the paramount chiefs and the women leaders were not really involved into it and they were like overlooking the dangers, the hazard that attach to that. (Health Worker, Lofa County)

Yeah, a curse on you; so, you go for healing. So, we targeted the elders, the zo, the traditional healers, we also the targeted the religious leaders. So, community engagement helped a lot, yeah it really helped. (same Community Stakeholder, Lofa County)

We had to do it at the community level, so after we noticed there was a lot of wasting of time from the Ministry of Health to come into this community. We had a team that divided a strategy of community leaders; a paramount chief in identical village and set up a little group. (Health Worker, Montserrado County)

The chief? Yes, all the authorities became involved [with the] county health team, that of [NGO name] and other partners, they all joined hands to come, after they believe it now that Ebola is truth. They realized that Ebola is truth. That is when those people came together and join hands to help the community and by that time more people were dying. (Health Worker, Lofa County)

A community organizer from a town in Montserrado County discussed how he organized door-to-door campaigns in his neighborhood. Teams of volunteers went and identified sick persons and escorted them to the nearby health center, he says that there were no Ebola patients from his neighborhood, in the quote below:

The community took the initiative to organize themselves, like for us, we organized ourselves. We put ourselves in a group and we go from house to house; we find sick people and we make sure those sick people were transferred to the hospital for proper care. So, as for me, my community, the ____ community¹⁰⁵ we didn't experience any outbreak and there was no symptom of Ebola in the ____ community. Because we mobilized ourselves into a group without anybody helping us. (Community Leader, Montserrado County)

In the next quotes below, a nurse discusses a checkpoint that was set up by a team of community volunteers off the main road that leads into central Monrovia. Every car that turned off the main road for this street was stopped and the person was asked questions to verify if she or he lived in the area. All visitors, including relatives, were turned away. Only those who lived there were allowed through. Another community stakeholder agreed that various communities had to organize; refer sick persons into care and patrol their neighborhoods. In addition, this phenomenon was not unique to the 2014 EVD outbreak, as local communities normally organize in some way in prior outbreaks:

Each person in this community will ask, "Where are you from?" "We have never seen you in this community. Please go back where you come from." And you will see these people at the junction [main street intersection].¹⁰⁶ When you enter, and they stop you, they won't be hostile or anything to you, but will ask you those questions and if the person say, "Oh, I got my mother here" or "I got my housing place here, like, where 'Mary' was but decided to come back" You will not enter your house. You will go back to where you came from until after the crisis. So, that was how community tracing and [the] Ebola started to be reduced. (Health Worker, Montserrado County)

But pre-Ebola, some of the past outbreaks were handled in a chaotic way, like Cholera outbreak was handled in a chaotic manner. No system, no structure, no coordination, no leadership, no good political will; so, it was handled at the local level or wherever the incident occurred. So, there was no national response to that. Maybe because they were not of a huge magnitude, so it was left for the locals to address. (Community Stakeholder, Montserrado County)

Community-level institutions played a role in emergency management. This did not always include traditional leaders, but a respected peer decided to volunteer or lead community engagement efforts. However, the extent and depth of involvement or effectiveness varied. An NGO worker described sensitization and bringing in traditional and community leaders into the fold; in other communities, they 'self-organized' without external help because of the perception that MHSW was ineffective. Local institutions helped to reduce EVD case rates by referring any sick person for care and reporting any deaths to the burial team.

As mentioned in section 4.5, although the hotline received many calls for burials, these teams were quickly overwhelmed. Thus, it is unclear how effective local institutions were at preventing local burials if many families waited for days with one (or more)

¹⁰⁵ Location omitted to protect the identity of the informant.

¹⁰⁶ Street name omitted to anonymize the identifying information.

decomposing corpse(s). This informant below, suggested that the epidemic curve went down after mandatory cremations were implemented by the government.

We have limited health staff in this country, okay, and what we have been doing to help disseminate information from the health sector to our people at the local level; so, when there is a meeting, a health meeting, we are indeed invited. You see the local chief go and the message is sent through the local chief of what can be done. Even though they are not health practitioners, but from the message, you can take some measures to save your peoples' lives. (Community Stakeholder, Margibi County)

The quote above explains that the information is only as good as the person giving it. The role and relationship with local leaders are vital to accessing the community and gaining trust. However, if local leaders do not believe health workers or those affiliated with state institutions, then this may hamper community engagement.

This last quote below gives insight as to why some communities self-organized:

It was organized from the bottom: communities were effective. We are in a system where the rich or well-to-do is not going to get down there, I mean they were flying out of the country. So, it was from the bottom, because the community was effective, so they had to take initiative. So, they became more proactive in order to save themselves and save their communities. (Community Stakeholder, Montserrado County)

4.6.2 Sierra Leone

This quote below from a health worker describes how local efforts helped community engagement. International volunteers were needed but would not have been able to access the community alone. This person says the government did not initially engage with health workers to be social mobilizers, but it was the WHO's intervention that did. This reveals that there were still some levels of trust in health workers if they were involved in community engagement:

Yeah, because without the health workers these things are not going out. Among the health workers, some of them were social mobilizers, some of them were part of the burial teams, [and] some of us were surveillance officers. We had to go out, these are our people. We know the language they speak, and they know us very well. Like, foreigners came, but if we leave them to go out into the community, they will not accept them and think this or that of them. So, they brought us together on the frontlines where we meet our people and talked to them and tried to bring them down [sensitization]. (Health Worker, Kailahun District)

The Kailahun District is the most eastern part of Sierra Leone and where the first case of EVD was identified in May 2014. The organization of paramount chiefs in this district, along with other traditional and religious leaders such as the *Sande* and *Poru* secret societies, implemented and enforced local rules and regulations of isolation and mandatory reporting. Informants say this happened right after the first case was announced. These are called bylaws and the paramount chiefs have always had the authority to implement bylaws; however, to have the council of chiefs agree to implement a set of rules district-

wide during an emergency period was unprecedented. Even more so, for the country's president to later find out about these rules and adopt them nationwide, by asking every paramount chief to implement these in his or her chiefdom.

Yes, those were some of the challenges and those attributes contributed a lot in breaking down the chain of transmission. If you see a stranger, a visitor that has not been there, and no satisfactory report about his or her coming and you harbor that person, you will pay 500,000 Le. (Health Worker, Kenema District)

This quote above explains the mandatory reporting bylaw. Any visitor entering a village had to report to the chief or health center for a health history and determination if they would be allowed to stay. The introduction before the chief would be to ask the traveler of his or her travel history (to see if one traveled from or through an affected area) and reasons for wanting to come into the town or village. Anyone that allowed a stranger to come and stay, without reporting it to the authorities, had to pay a fine of 500,000 Leones (Le). A stranger is considered a non-resident of the village or town. So even an adult child or relative visiting someone had to do this too.

Under the bylaws, all sick persons had to be reported to the chief or the nearest health facility. If not, then a fine of Le 500,000 was given. This is equivalent to 60 USD and to put this in perspective, a nurse in Sierra Leone makes about a million Leones per month or approximately one hundred U.S. dollars. So, for a rural farmer or someone working in an unskilled profession, this would be equivalent to a month's salary or maybe more.

Movement was also restricted, such as visiting a neighbor's or relative's home, even if that person was sick.

When the epidemic came, it was not politics and it was not resources, it was knowledge. The nurses told them that if you touch a sick person you will die. So that's what they heard...So, because of that information, everybody became scared. So, people are afraid of bringing their loved ones to the hospital, once you know you have a sick person and if you touch that person you will die, Ebola or not, that affected. Not until the bylaws were put in place that if you have a sick person you should take him or her to the hospital. (Community Leader, Bo District)

This quote above shows that the bylaws affected social cohesion in communities as visiting and caring for a sick relative is a moral duty. Even for nonrelatives, it is common to visit and stay with someone if there is news that she or he is unwell. This demonstrates how institutions can influence cultural changes. In addition, the information failure brought fear and people avoided the health facility, but then the mandatory reporting bylaw corrected the social cost of at-home caregiving in this community.

In the many rural villages, the road network is poor and, in some places, nonexistent. This means the main form of transportation is via commercial motorbike and their drivers called *okadas*. The isolation measures impacted this commercial industry as fewer people

were traveling and *okadas* were no longer allowed to carry any sick persons on their bike, something that was all too common beforehand. In addition, a curfew was implemented. *Okadas* were not allowed to transport people after ten o'clock in the evening or else, face a fine of Le 400,000. Community members also had a curfew and could not leave their homes after this time.

Congregations were also prohibited, some towns removed public benches to discourage community members from congregating. Since the bylaw said "congregating" or "public gatherings," this also meant that some religious services and funerals were prohibited. Schools were closed and so were markets too. In terms of worship, masses and prayers were modified to discourage touching or sitting too close together, for example, getting rid of the "peace be with you" ritual in the Christian services. Many areas canceled nonessential public events, except town halls to give updates about EVD and other necessary announcements. Community leaders participated in health sensitization to give information about EVD and other health and hygiene practices such as handwashing.

Checkpoints were established in villages across the chiefdoms too. One informant revealed that the fines helped to pay for enforcers, who patrolled the village, to deter any offenses. Public facilities such as health centers had handwashing stations where everyone had to wash their hands before entering and after leaving the building. Only a few people could move around freely, mainly those affiliated with the emergency response, such as a health worker or a burial team.

They told us, "Who so ever has a sick person at home should report to the nearest PHU or main practitioner that is closest to you." If you don't do that, and they realize that, they will fine you 500,000 (Le). And Mende people will fear fines so much. They told us that we should not touch corpses. When there is a corpse, a dead person, we should call [a] medical practitioner. You know the infection between your loved ones- when your love one is dead. You want to touch or clean it or so, but when your loved one is dead, we are infected by that, so we never touch any dead one. And travel was canceled, because if you traveled, they wouldn't allow you to sleep in any other places. So, I think that saved us greatly...So the 14 paramount chiefs in Kailahun district came together to put the bylaws together and communicate that to the government, so that was in effect. So, all the districts in the country started implementing it, which worked effectively. (Community Leader, Kailahun District)

No, it was from the bottom to top. We had agreed on these things in our meetings and we decided to operate it. There was a time we met with someone from Kailahun, [redacted] because they were the first people to start making bylaws. We called them to come and share their experiences with us and that one was very good. So, we had to present ours and he presented theirs and told us how they were able to overcome a lot of difficulties with the bylaws. So, we had to copy almost all of the things they agreed on and we just added few, that one was very good. So, there was even inter-district collaboration, so towards the end when we had more cases in other districts, people were taking from here to go and put it over there. (Community Stakeholder, Kenema District)

The first quote above discusses some of the bylaws; mandatory reporting, notifications for any corpse and not to undertake a corpse for burial, and finally, isolation. The second quote describes how a taskforce heard about the bylaws in the Kailahun District

and decided to approach their paramount chiefs and asked if they could do the same. They deliberated and created their own set of bylaws to implement district wide. There were some modifications from the 'Kailahun template' however, the main examples the person gave were restricting movement and mandatory reporting.

For instance, what had made Ebola to finish sooner, was number one, they restricted the movement of people from one place to another. Then, there were bylaws that nobody could harbor anyone from different places. If somebody comes from Daru [in Kailahun] to stay here in Kenema, this person may not be lodged and the chiefs or authorities need to be alerted. However, if you happen to hide this person, you happen not to present the stranger to the authorities, then you will have a special fine to pay of 500,000 Leones. People were afraid of that huge money because during Ebola, all movements were ceased. No one went out to search for food or work, so when the money issue was stated [fines announced] people were afraid about how to pay that. So, that alone restricted the movement. Then when you have gone from one place to another place, we had public points where you had to wash your hands, if you were allowed to move around. You needed to present a particular document as well as wash your hands in these public places. This also helped in the fighting of Ebola. (Health Worker, Kenema District)

So, when those bylaws came into effect, patients were now making use of the health facilities. At that time [the deflated economy], having 500,000 Leones was not easy; so that was a turning point... (Health Worker, Kailahun District)

Yes. Every bylaw put by the community authority, went through the health professionals. There were health advices from the professionals. [And] yes, [we were] very included in it. (Health Worker, Bo District)

The first quote from the Kenema District says that the fines created compliance as economic production had stopped, so few people would be able to pay the fine if they violated the bylaws. The second quote echoes this too. The final quote explains that health workers were consulted with, regarding the kind of bylaws to enact. Thus, we see that many chiefdoms adopted the bylaws, and these laws were fairly similar. Additionally, the involvement from the community to create them varied. For example, some chiefs consulted with health workers, religious leaders, or secret society leaders.

So, like you said, the Ebola came here in March 2014, it was not taken seriously, and the bylaws were not in place. Not until 2015, when they started hearing it in Kenema and there were a lot of ambulances passing now so they became worried. So, the chiefs had to come together and make these bylaws. Especially when the military intervened and had checkpoints all over with the temperature tester that they point at you. So that was also scary...That is when Baoma chiefdom got together, after they heard of other bylaws across the country. They came together because this is the main highway where ambulances to and from Kenema pass with Ebola patients. (Community Leader, Bo District)

In this quote above, the person was asked if he remembered when the bylaws were enacted, as this area of Bo District had never reported an EVD case, despite being located off a major thruway and having a large market. According to him, the chiefdom implemented bylaws later in 2015, after the phase two scale up and the Sierra Leone military set up checkpoints.

So, part of their strategy was to prevent Ebola, they caught five bike riders and fined them 500,000 Leones each. So, that money was given to the security men who were looking after this town, so that helped greatly. Then, they put an end to every society's initiations until the end of Ebola. So, these were measures put in place to prevent Ebola from reaching here, this is what helped the health system...So, during the Ebola, the chiefs came together and brought bylaws. They fought very

hard and never had a case here in this town. So, whosoever was moving around [violating isolation] was fined 500,000 Leones and had to return to their hometown. (Community Leader, Bo District)

This quote above from a different community leader says that to end EVD, they suspended initiation rituals such as female genital circumcision.¹⁰⁷ It says that this was until the end of the outbreak, however, some parts that I visited still had the ban in place. This informant also confirms that this area did not have a single reported EVD case. The *bondo* had received much attention over the last three decades as it is a controversial ritual, however, this was at least suspended during the epidemic.

All informants that discussed the bylaws referred to this as a positive governing act that changed the disease spread, except for the one village in Bo District that did not report an EVD case, so for there, it was more of a precaution. One informant from the Kenema District, says that the bylaws were top-down, as he referred to the President decreeing a national emergency, where all chiefs were asked to implement the bylaws. Informants from the Kailahun and Kenema districts, which were the first to implement these, reported significant drops in deaths, and weeks with no new EVD cases. Rules and enforcement not only helped to change behaviors that were 'risky' and costly during this time, but also gave protection to workers and volunteers to conduct contact tracing, safe burials, and caretaking in the health facilities. However, isolation measures were not universally accepted. For example, this informant says that they did not initially consider how food and supplies would get to people in isolated areas if movement was restricted. This person below was interviewed in Bo District but had also worked in the northern district of Koinadugu, which borders Guinea:

One of the weaknesses of the policies, it restricted the movement of people and thereby stopping the flow of food and items. It kind of escalated the hunger among the population, especially those that needed materials and rely on the movement of goods from the urban centers, on a daily basis. It abruptly stopped. So, people were faced with starvation, having a meal was difficult. Those policies had not been looked into before they were implemented, like, 'how do we provide the standing population with food and maybe medications.' And one of the strengths I identified here, some regions, those that followed the policies, stayed off the outbreak totally. Like, I remember when I was in Koinadugu, which is far north and the people there, heeded to the messages and the laws that were put in place, like you should not get close to the dead or bury them, or people should be quarantined or reported of any suspected case to the authorities. I think it worked there and stopped the chain of transmission for those communities there. (Health Worker, Bo District)

The traditional local institutions may have had the effect of regaining the reputation and trust in the community. Thus, despite health workers having a limited supply of

¹⁰⁷ Female Genital Circumcision, sometimes called Female Genital Mutilation or Excision, is practiced on almost every continent across the three major monotheistic religions. This topic has shaped discussions on gender equality, identity, Western feminism, and social development. Including efforts to eradicate it. See Ahmadi (2007), Bekers (2010) (for its representation in literature), Miller-Bashir (1997), and Parker (1995).

resources; local institutions had an effect of not just changing behaviors but also changing community perceptions.

4.7 Governing the Outbreak

This theme takes a holistic perspective of how the EVD outbreak was governed in each country. This is from the informants' views of the strength and weaknesses of the response, using a polycentric institutional framework.

4.7.1 Liberia

As explained in sections 4.5 and 4.6, the health centers were chronically operating in under-resourced and understaffed conditions before the 2014 EVD outbreak; information failure in terms of official messaging and state institutional failures to contain EVD initially, created fear, stigma, and panic. In the prior section, the theme described how some communities mobilized to change behaviors and educate people about EVD. However, many health workers were directly affected by the disease and left the centers. Per combination of these factors, some facilities closed during the epidemic. This social cost led to negative externalities as potential Ebola and nonEbola patients were less likely to get care in time. In addition, the risk of Ebola patients traveling over greater distances to get to an ETU may have exposed the virus to other people. The common factor that reversed this, according to health workers, was training and supply of PPE; these were attributed to external partners. This gave them resolve to return to work at an ETU to treat patients:

[T]hey (NGO) advise them, the people will give their information to them, "this is what you people supposed to do." But no trust, how you will advise somebody who don't trust you? It was very difficult for us. So, the people too, they said they can't do anything, otherwise. October 1st, we re-opened the clinic, they sent for all of us to come. (Health Worker, Lofa County)

Health workers recounted the number of phone calls received each day regarding someone who died or whole departments were lost. The hospital and clinics were no longer viewed as places where people were treated, and lives were saved. This was not only the perception of nurses and doctors but also pharmacists and laboratory scientists, whom until the epidemic, did not consider themselves at risk for nosocomial infections because of their limited interactions with patients, as this pharmacist says:

Like, before the Ebola, we had patients taking their own prescriptions from the prescriber and carrying it to the pharmacy to get their medications. That was a risk by itself, because not knowing the condition or health status of the patient and the patient handles the prescription to give to you. You, as a pharmacist, are not wearing gloves; so, you directly grab the

prescription with bare hands and serve the medication. There could be microbes on the paper that could affect you. (Health Worker, Margibi County)

When aid resources began scaling up in phase two, announcements of charities and NGOs arriving with equipment and expertise were said to be the reason for returning to the health centers. The WHO and other international responders were viewed as trustworthy and reliable entities that would pick up where the government could not. These organizations would deliver where the Liberian government did not, and they would serve the community where state institutions had not. Aid resources not only brought biomedical resources, as explained in chapter two, but these had also brought professional development and benefits that MHSW did not deliver to the health workers, such as capacity building, training, a consistent salary, and equipment.

Yes, they brought instruments and a lot of things that will help us to protect ourselves from getting Ebola. And we got a lot of training from the Ebola outbreak and right after the Ebola. During and after the Ebola, we had a lot of training concerning Ebola. How to care for patients, how to triage patients at the gate before they come in, to know between the patients who come first and who last, who should be first to be treated. At least the Ebola helped us, we went through a lot of workshops and it was successful. (Health Worker, Montserrado County)

This nurse describes above the experiences with training. The training was not always specifically on disease outbreak management but also establishing standard operating procedures that one would expect to find in the hospitals such as the triaging of patients. She says this was a weakness in the healthcare system for many years that at least, the Ebola epidemic helped to rectify.

After few months, we got some aid from other countries and they came. We went for several workshops and from that workshop what we started doing-- like, before, when somebody come, "my skin hot" and we touch them, we never use to do it again. Like, if your skin is hot, after the workshop, you come, we never touch you, we just go close to you and know your temperature. That was some of the benefit that we achieved. (Health Worker, Montserrado County)

In the text above, a nurse describes how before this training, workers would physically touch a patient to determine a fever, but after the workshop, they use new protocols. Using temperature as an example, these protocols were safer for the healthcare practitioner.

However, sometimes PPE and training were not always effective as discussed in the quote below:

The strength was, they were able to provide a PPE for us; and the weakness was, we were not able to use the appropriate PPE to deal with the patient. That was our weakness to know which type to wear, to deal with the patients; but the strength was they provided the PPE for us to use to save our patients. (Health Worker, Margibi County)

As discussed in chapter one, since Liberia is in post-conflict development, many NGOs and charities were already present when the Ebola epidemic began. However, some

were struggling to retain staff and perform community sensitization because of fear and stigma. Also, NGOs are normally there to fulfill a specific contract or target as described by the community stakeholder in section 4.5.1. So, the staff that was present may not have had the capacity to effectively respond. Informants mentioned that aid from non-Western countries, such as Uganda or the Democratic Republic of Congo, had arrived earlier in 2014. However, biomedical tools, drugs, and ambulances are useless with no one to operate them. NGOs had to reach out to health workers first, to promise the safety and security of their lives by providing the Infection, Prevention, and Control (IPC) training,¹⁰⁸ PPE supply, and a consistent paycheck.

A multilayered response governed this outbreak. State institutions were able to receive and implement aid resources to recruit personnel and local institutions helped with behavior changes and engagement efforts. However, the collaboration between these institutions was not completely coherent. Community engagement efforts were scattered and depended on how community leaders were recruited through aid organizations, state institutions, or self-organized. In the communities where local leaders were recruited by NGOs, it was reported that these leaders were trained and participated in supporting the NGO's efforts. However, other informants discussed self-organizing in the community. In some parts of Montserrado County, community leaders were conducting education and dissemination of information to prevent EVD. However, when NGOs and state institutions were asked to support their efforts, community leaders and volunteers did not always receive help:

Even during the Ebola, what we notice is that, there was some money allocated for the communities, but it was process through the representatives from the various districts. Like for this district, where [Redacted] is the representative, we learned the money was passed through those people for the district to fight the Ebola, but we didn't see that in our own place. The only thing we noticed is that when we first launched our community Ebola team, invited stakeholders, we invited [Redacted] who is the representative for this district, and he came. When he came, he first started with L\$ 10,000¹⁰⁹ and then we invited Robert Sirleaf [son of President Johnson-Sirleaf] and he came in too and gave us [a] few buckets and some rice, to say you have a special link with the government and the community, [but] it didn't happen that way. Then from there, what we did on our own was, we bought buckets and came to give it to people too, to wash their hands. We got in contact with a lot of NGOs, but they couldn't come to our aid, but people benefited too, other people benefited because they have the Ebola there. So, they have NGOs helping that community apparently, but they didn't come to us because we didn't have [an] Ebola outbreak [here] apparently. Maybe this is the reason assistance was not coming to us. (Community Leader, Montserrado County)

¹⁰⁸ Health workers discuss how this training helped to develop infection control skills, such as learning about nosocomial infections and how to prevent them, safe handling of sharps and other medical waste, and proper use of PPE. This was referred to in chapter two as 'barrier nursing,' however, this term may also appear in interviews.

¹⁰⁹ This roughly converts to about 100 USD at that time.

In areas where local leaders were not engaged, at least not in phase one, then efforts to contain the disease may be hampered. This is evidenced by the NGO-sponsored clinic that closed until October 2014. However, when multiple institutions are working collaboratively, it may produce a stronger response and service delivery, such as the NGO that engaged traditional leaders or the nurse in Montserrado County who felt that state institutions engaged with health workers to improve outcomes. However, while some areas demonstrated a strong local response such as communities self-organizing, this can assist with demand-side barriers by reporting sick persons and infectious corpses, but if there are barriers on the supply-side (like burial teams being overwhelmed and leaving little choice for surviving relatives), then this may also hamper efforts to contain the disease spread.

4.7.2 Sierra Leone

As mentioned in the first theme, misinformation and stigma lowered confidence in the health system. Many people avoided seeking healthcare from hospitals because of a mixture of fear and misinformation. In the second theme, traditional leaders and community stakeholders deliberated on bylaws to help address some of these demand-side challenges. In addition, some leaders helped in community engagement too. There was a coordinated effort to bring aid resources to all affected regions in the country and thousands of people were recruited to assist in the response. As mentioned in chapter two, contact tracing, early clinical intervention, and safe burials are key components for controlling the outbreak of a Viral Hemorrhagic Fever (VHF). Full-body PPE, knowledge, and experience are also important so that health workers can identify the disease earlier. A few experienced NGOs had some expertise and some resources to combat the disease, but what they lacked was power, safety, and staff.

Like I was saying, for Sierra Leone, Ebola is very new. It came in and nobody had any idea about it. Of course, we know it is one of the viral hemorrhagic fevers and you can prevent it in the same way you can prevent Lassa fever, and we have Lassa fever in this country. But the way it spreads, it's faster than Lassa and we did not have an idea of what to really do, and again, there were a lot of denials. People had different interpretations of the outbreak.... Yes, like it was a kind of plan to --- it is hard to say. There are certain things I cannot say that connect to [redacted],¹¹⁰ but it had political connotations. People were alleging a lot of things that were not even correct, like we were collecting blood samples to send, and they are giving injections to infect individuals. (Community Stakeholder, Kenema District)

This informant above says that there was already some expertise on VHFs, because of prior experience with Lassa fever and the only laboratory equipped to test for VHFs is in

¹¹⁰ Employer is redacted to protect the identity of the informant.

the Kenema District. However, Ebola spreads more quickly than Lassa and as the death toll climbed, stigma and negative perceptions developed that EVD was not a natural disease outbreak. However, as mentioned earlier, some people also feared nosocomial transmission at the health centers. People avoided the health centers, including the ones partnered with an NGO as stigma was formidable in the community, by then, people had received the information that EVD was not curable. Consequently, some did not understand why they were still being asked to go to the hospital for an incurable disease. So, this raised suspicions. As explained below, one of the strengths in the response, was the involvement of community leaders. The informant says that if this was done with HIV/AIDS, another disease with a history of stigma and discrimination, then local leaders can help to mobilize the communities too, and not only pass bylaws:

If you are talking about successful programs in a chiefdom, we have to go through the community leaders. So, the paramount chief is the head, the administrative head and he has his chiefdom divided into sections and each has a chief. And each section has villages and each village has a chief. So, until we bring all these people together, to get this information, you will find it difficult for people in the village to understand [comply] with what is going on. So, the local leadership has been very useful, not only in Ebola, although in Ebola it was more useful. In other areas, like what has been making the HIV project very difficult, the strategies we put in place during Ebola, if we put that in place in other areas, it will be very easy for us to eradicate other problems. (Same Community Stakeholder, Kenema District)

Survivors of EVD had a difficult time re-integrating into their communities because of stigma, as explained by this nurse in the Kailahun District:

So, the thing [about] Ebola, when you are passing, they will say that this person had Ebola or is an Ebola survivor, so people have to know you. However, HIV is not like that. They don't know who is an HIV patient, and besides, during Ebola people were preferring to get HIV than Ebola. They thought HIV was a better illness than Ebola. (Health Worker, Kailahun District)

Traditional leaders also played a role in reducing stigma, by accepting survivors in the community. The first quote below from a traditional leader is in response to my question about how survivors are perceived in his village. The second quote is from another community leader, regarding the presentation and acceptance of EVD survivors. And the final quote is from a traditional leader who was part of community engagement and social re-integration of EVD survivors with an NGO.

At this point in time, you cannot even identify who is a survivor, we are all the same. (Community Leader, Kailahun District)

So, after the Ebola, the doctors brought the Ebola survivors and said these are our brothers, our family members. (Community Leader, Kailahun District)

They accept the people, they know the virus is no more and it is gone. So, they accept them because they are their brothers and sisters. There is a village called [redacted], they have a lot of survivors there and they used to go there and talk with them and mix with them, so they are integrated. There is no stigmatization. (Community Leader, Bo District)

The bylaws regulate behavior to reduce the spread of EVD and it facilitated cooperation and behavior change. Early clinical intervention and safe burials were able to proceed, and health workers (including NGO workers) were able to work safely under the chief's authority. Resources such as contact tracing, safe transportation, and clinical care that were brought by external partners were made more effective as explained below:

Bylaws from area to area...you know when announcements go through parliament it is a process and a longer time, but with bylaws it is quicker here with the local chiefs. I think that is why the government also dealt with the local chiefs later; that they should go and man checkpoints in their localities during the Ebola. Once they were involved, they created bylaws and created a level playing ground for the medics to come and work protectively. (Health Worker, Kenema District)

In the above quote, this worker also says that the government chose to implement the bylaws because the parliamentary process may have just been too slow. The bylaws made it easier for health workers to do their jobs and work under the protection of the chiefs, without fear for reprisals from the community. As mentioned in section 4.5, health workers reported discrimination and harassment.

In some areas, chieftom officials and humanitarian workers worked in tandem after the phase two scale up. However, in other areas, like the Kailahun District, EVD was resolving before the scale up of aid or government resources. This informant below describes that local health workers and community stakeholders worked to stop the disease spread. This was during phase one when the government and the international community did not respond effectively. When they finally did, it was in a manner that seems to take over or take credit rather than collaborate with local actors:

They create the NERC, the National Emergency Office was created, and at the district level, the District Emergency Operations office was created; where there were other people that were recruited, and they were managing the Ebola. Like for this district, there was some conflict among the health workers, because at the time the emergency unit was created, we had already done away with the Ebola here. It was not actually here again. Then you take the responsibility away from the health workers that they were not up to expectations. So, most of us were annoyed, because we had already done the fight. Instead of compensating us or give us thanks, you bring in the manner that you bring people to come and take over for us. (Health Worker, Kailahun District)

However, it cannot be said that aid was not completely present, as the interviews presented in this subsection depict NGOs and faith-based charities assisting but with limited resources.

Community stakeholders reported that the relationship between state and local institutions was cordial when the bylaws were adopted at the national level. However, cordial does not mean without challenges or politics. For example, this health worker says that the initial response from the ministry, to send the military to enact isolation, was not

effective. Local health workers should have been consulted with first, on how to stop people from moving:

For example, if you take a nonmedical practitioner and you make that person a minister of health; [but] he or she knows very little about health issues in the country. So, he or she may do the wrong thing. That was one of the reasons why the Ebola spread very quickly in the country, because then, our minister was a non-health practitioner and she was made [the] health minister. When she heard of Ebola, instead of sending health professionals, she decided to send military personnel, who don't know anything about health. So, the thing spread very fast inside the country; not until later when they decided to change the entire system. Health professionals are very important in health planning, especially at national level. (Health Worker, Bo District)

The party in power was the All People's Congress (APC), which historically, is dominated by the Temne and Limba ethnic groups from the northern region, and the southern and eastern provinces are predominantly Mende. So, there may have been some identity politics in the response or, political missteps, such as the minister sending troops without consulting local stakeholders. However, while much had been speculated in the past about ethno-regional tensions in Sierra Leone, the collaboration of both institutions, especially since the bylaws started in the Mende chiefdoms,¹¹¹ transcended this.

The first quote below is a response after I asked about the strengths and weaknesses in the governance of the response. The second quote is from another health worker who was asked the same question regarding the strengths and weaknesses:

They [government] implemented some standard operating procedures (SOPs) during that, and then there were other NGOs and they did some massive recruitment, which helped too. They involved the military officers and other volunteers to look for contacts. So, at the time, we did a lot of surveillance. There were surveillance officers everywhere, they recruited surveillance officers. This all helped to bring the situation down. (Health Worker, Kailahun District)

So, they organized meetings with local chiefs and local authorities. We told them what to do, the things that will help eradicate the Ebola. So, they knew if they didn't take it seriously, it will affect them, and it will affect the entire country. (Health Worker, Kailahun District)

There was a multilayered institutional response addressing different factors during the outbreak. Aid supplied some of the technical resources, but not all health workers reported these resources as motivating factors to continue working, except for hazard pay, or to change the fear and perceptions in the community. Rather, it was the involvement of chiefs through bylaws and community engagement efforts that helped. This also included accepting EVD survivors to return to the communities. This corrected the misinformation that EVD was completely lethal and incurable, and restored trust.

4.8 WHO EVD Surveillance Data

¹¹¹ The southern and eastern regions of Sierra Leone are predominantly a Mende ethnic group. See chapter one, section 1.4 on the history and background of the country.

In August 2014, the WHO declared the Ebola epidemic in West Africa, a Public Health Emergency of International Concern (PHEIC). It began scaling up aid resources and keeping track of suspected, probable, and confirmed new EVD cases and deaths, and redefined the old cases from before the PHEIC. Technical assistance arrived over eight months into a disease outbreak, and thus, much of the data before this are sparse as there was not enough logistical support to keep track of EVD cases and deaths. I acknowledge that the data may not be completely accurate, however, given that this is the WHO's report, it is the most reliable and widely accepted data available.

Sierra Leone had 14,124 total EVD cases with 3,956 EVD deaths and Liberia had 10,675 EVD cases and 4,809 EVD deaths from December 2013 to June 2016 (World Health Organization, 2016a; World Health Organization, 2016d). By dividing death rates by the total case numbers, this means that the death rate in Sierra Leone was 28%, while Liberia had a 45% death rate of EVD cases, according to these figures provided. In addition, Sierra Leone identified more EVD cases than Liberia, at almost 4,000 more cases, but it recorded nearly a thousand fewer deaths than Liberia (World Health Organization, 2016a).

The EVD cases and deaths can be interpreted via community engagement efforts of contact tracing, referral into care, and quality of care. Contact tracing efforts are meant to find each person that is connected to an EVD patient or in some villages, go door-to-door to find any sick person and refer him or her into care. As discussed in chapter two, the early treatment of a VHF increases one's chances of survival.¹¹² So, in a coordinated engagement effort, there could be higher diagnoses but a lower death rate, if more people are found and referred into care early.

4. 9 Summary

Findings from the fieldwork were categorized into three broad themes that showed parallels and differences in the response during the 2014 EVD outbreak. In both countries, informants discussed their respective government's initial response and revealed a consensus of state institutional failure. This first theme achieved one of the research objectives in identifying the challenges of managing the EVD outbreak; these were information failures and social costs that hampered efforts to contain the disease. The

¹¹² See the literature on prior EVD and the Marlborough virus disease outbreaks in chapter two, section 2.6.2.

second theme discussed interventions led by community and traditional leaders to contain EVD. These efforts addressed the demand-side barriers and encouraged health seeking behaviors and discouraged 'risky' behaviors, such as unsafe caregiving and burials. Liberia and Sierra Leone conducted community engagement differently, with Sierra Leone's strategy becoming a bottom-up policy for national emergency management.

The third theme discussed how multiple institutions governed the outbreak, specifically in phase two when aid resources were scaled up. Liberian informants viewed this more positively as making a difference in the response. However, there was a difference between how health workers and community stakeholders perceived this. In addition, there was not a consensus that aid helped in the demand-side barriers, except for providing health workers with resources and pay, so they can return to work. In the last section, the data from the WHO reflected how effective community engagement efforts were in each country. Thus, the findings support an interpretation that effective contact tracing led to higher EVD cases but lower death rates. This was exhibited in Sierra Leone.

CHAPTER FIVE: The Discussion

At the end of the research, we try to understand the meaning and significance of the findings.

5.1 Introduction

These findings build on the arguments identified as hidden transcripts (Scott, 1992), which feature local community leaders responding to the outbreak with emergency management regulations and locally-derived solutions (Abramowitz et al., 2015; Parker and Allen, 2018; Parker et al., 2019; Perry and Sayndee, 2017; Richards, 2016; Van der Windt and Voors, 2020). Community leaders governed effectively and restored social cohesion and trust, and local solutions helped to stop the Ebola Virus Disease (EVD) outbreak. However, these interventions were not always supported by external partners. The public transcripts (Scott, 1992) on health interventions have historically ignored local solutions (Benes, 2017; Mustapha, 2006); encouraged adoption of Western-derived practices to the detriment of local communities (Werner and Sanders, 1997); or marginalized these responses as culture or “bad behaviors” (Johnston, 2015; Moran, 2015). Evidence from the field extends the theoretical framework of institutional quality on how addressing the demand-side barriers reduced negative externalities. The evidence also showed that aid resources were effective in reducing the supply-side barriers, however, this was not without challenges and not all costs were addressed by aid or local leaders. These findings are not without contention, as some public transcripts say these local solutions were not effective (Boland and McKay, 2018; Enria, 2017; Wilkinson et al., 2017). This research specifically, and the debate broadly, on the role of aid and community leaders have policy implications for future disease outbreaks.

The first section, 5.2 is a synopsis of the informants’ narratives on state and community-level institutions during the outbreak. The discussions of self-organizing during the emergency period build on Hewlett and Hewlett (2008)’s arguments and the hidden transcripts on this EVD outbreak. The second section, 5.3 is the market approach of how local intervention corrected some demand-side barriers and the extension of the theoretical framework. In addition, it discusses some costs that could not be reduced by local interventions. The third section, 5.4 examines the variation in the interviews where some informants felt that aid resources made a significant impact while others felt that it had not. Additionally, it gives a holistic view of how multiple institutions governed supply and demand factors in the market. The final section discusses policy implications from this research.

5.2 Understanding Local Response and Perceptions

This section addresses the research objective of how the response of state and community-level institutions differed; it explores the narratives on state institutional failures and the significance of the community leaders' actions. In prior public health emergencies, communities had self-organized. These examples of self-organizing are seen in Hewlett and Hewlett (2008)'s observations of rural communities enacting emergency management regulations in multiple EVD outbreaks. The thesis builds on this concept of self-organizing communities. The last subsection, 5.2.4 engages in a critical discussion on how local institutional responses were perceived in the public debate about the EVD outbreak specifically and health interventions in general.

5.2.1 Liberia

Community members organized door-to-door campaigns and checkpoints, often without external assistance, including that of the Ministry of Health and Social Welfare (MHSW). However, MHSW was aware that different communities were "stepping up" and was supportive of this, in principle (Sirleaf, 2014). None of the informants mentioned curtailing burial or funerals, even though the Liberian government had banned it and implemented mandatory cremations. Training workshops were held in churches and other places to show people how to correctly do this. This builds on Perry and Sayndee (2017)'s findings of community-led engagement in Liberia.

5.2.1.1 Perceptions of State Institutional Failures

Communities were organizing and changing behaviors before phase two of the outbreak.¹¹³ According to the Liberian member checker, this largely had to do with the community's reaction after MHSW announced the extent of the Ebola epidemic and advised people not to engage in sexual intercourse.¹¹⁴ Informants believed that the government was not responsive or did not take it "seriously"; the latter could refer to confusing headlines from MHSW's announcements and guidance. According to Subissi et al. (2018), scientists believe there was a patient in Liberia infected with EVD via sexual transmission. This led to

¹¹³ Phase two starts in October 2014. This period is the scale up of aid resources after the World Health Organization (WHO) declared the epidemic a Public Health Emergency of International Concern (PHEIC) in August 2014.

¹¹⁴ See feedback from member checkers in Appendix C.

an advisory warning EVD survivors to be cautious when engaging in sexual relations as the virus could be present in the semen for several months (Bullard, 2018). Therefore, it may be possible that this scientific discovery of the first-ever recorded sexual transmission of EVD could have led to some confusing headlines (an information failure).

In past disease outbreaks such as Cholera, it was common for state institutions to have a weak or nonexistent response and it was always up to local communities to fend for themselves. Hence, leadership tends to come from the local community and not the state. This builds on the discussion of the rural and urban divide that was discussed earlier regarding the historical legacy of Liberia's dual state system.¹¹⁵ The rural counties have rarely relied on leadership from Monrovia and political actors in Monrovia reacted to issues that affected Monrovia.

However, informants in Montserrado County also said there were state institutional failures despite proximity to the capital. Some believe that when 'big people' or important persons were affected or threatened by EVD, this was when the state responded. Also, big people such as an elected official or senior hospital administrator had left the country at the time too; demonstrating that those who had the means could and did flee, leaving behind those who could not (Butty, 2014). State institutional failure is not just a failure to deliver goods and services, it is also a failure in accountability and trust. This reflects the informants' perceptions of being abandoned and not trusting those in power to be accountable to those without power.

5.2.1.2 The Role of Local Leaders

Some chiefs did not assist in raising awareness of EVD. They may have even worked against efforts by spreading rumors and misinformation. The latter point is crucial to note because it demonstrates the power and influence of local institutions and whether this can be used for or against a specific cause. In other words, if an external actor such as an aid worker, health worker, or development practitioner is not able to convince local leaders to change a norm or behavior, then the likelihood of this happening is low. Eventually, there was some success in getting TLIs involved in the response and to assist with sensitization and engagement.

¹¹⁵ It is briefly discussed how Monrovia was a settler colony in chapter one on page 11 and the rural interior and indigenous ethnic groups were incorporated in the mid-twentieth century under President Tubman in chapter two on page 68.

Only one community stakeholder felt there was a response from the government in the beginning: a county official appointed by President Johnson-Sirleaf. This person says the county office acted under orders from the administration. However, as mentioned in chapter one, the county superintendent office is an anomaly because it does not liaise with the ministries (Nyei, 2014). Nonetheless, this builds on Pailey (2017)'s argument that various actors assumed public authority, where the state lacked legitimacy to do so. This played a vital role and even the administration urged communities and local leaders to self-organize (World Health Organization, 2015b). However, this was not mobilized into a coherent national strategy until after a decline of major case incidences; its effectiveness to monitor and enforce everywhere was limited (Kirsch et al., 2017).

5.2.2 Sierra Leone

At the beginning of the epidemic, some facilities had access to resources that other facilities may not have had. This depended on who the external partner was, the commitment or relationship to the local community, and at what stage they were in their partnership contract. Some organizations left or were ending their commitments right before it started, and others were already there but did not have enough resources or the right resources to combat EVD.

5.2.2.1 Perceptions of State Institutional Failures

Many informants say the response of the central government was part of state institutional failures that have long plagued the country. The first EVD case was confirmed a few days after detection in the Kailahun District; however, no safeguards or provisions were made after this announcement. In other words, the resources, equipment, and training were not scaled up to address a growing crisis in the nation's far eastern province.

The government failed in its moral duty to health workers and volunteers during and after the crisis. Many health workers had sacrificed so much and some, their lives, to continue serving during the emergency period. The example of Dr. Khan was a pivotal moment.¹¹⁶ Many health workers did not receive any recognition for their service, let alone a regular paycheck. This failure by the state has been linked to corruption. Ross, Welch, and

¹¹⁶ The country's most famous health worker and virologist, Dr. Sheik Umar Khan, was well known for treating Lassa fever patients (another VHF) and died from EVD. Maxmen (2015a) and BBC News (2014) report that his death triggered fear and realization of how serious the epidemic had become.

Angelides (2017) report that the Ministry of Health and Sanitation (MOHS) had a list of fake health workers to distribute hazard pay. This resulted in many health workers not getting paid and subsequently striking. Many informants described the discrimination, abuse, and harassment for wearing their uniforms, this was a disintegration of social norms. Along with the failure to provide clinical and infrastructural resources for the health system, state institutional failures were also the inability to protect health workers and lead in a crisis.

5.2.2.2 The Role of Local Leaders

Traditional leaders were beneficial in restoring trust, particularly by leading engagement efforts. These leaders were key to the social re-integration of EVD survivors within their communities. Information failures emphasized that EVD was incurable rather than early treatment (Richards, 2016); hence, since people believed that EVD was incurable then anyone claiming to be cured was not trusted. Many EVD survivors were not accepted back into their homes or communities for fear that the person was still infectious (World Health Organization, 2014d; World Health Organization, 2015d). Many traditional leaders publicly embraced and welcomed survivors back into their neighborhoods, thereby helping to reduce stigma and maintain social cohesion and peace in local communities. In addition, by enacting a bylaw to report sick persons to the health centers, helped to restore some legitimacy to the health workers. Some health workers reported an increase in services after the bylaws. This aspect of trust and legitimacy is a surprising finding that was not discussed in prior studies on the bylaws or the involvement of chiefs (Parker and Allen, 2018; Parker et al., 2019; Richards, 2016).

5.2.3 Perceptions of Locally-Derived Responses

Media sources gave much attention to ‘bad behaviors’ of local people continuing to bury loved ones, avoid health centers, or escaping from them (Bullard, 2018). Building from the discussion in chapter one,¹¹⁷ the discourse of ‘bad behaviors’ is not unusual in health interventions as it was used during the height of the HIV/AIDS pandemic, to explain how ‘highly sexualized Africans’ were spreading the disease (Caldwell, Caldwell, and Quiggin, 1989; Johnston, 2015). There were warnings to cease certain activities that may spread EVD, such as home care for the sick or conducting funerals. However, these activities continued in

¹¹⁷ See in contextual chapter on pages 11 and 43.

some areas, and thus, local communities were not seen as rational or their behaviors were regarded as rigidly religious or superstitious (Gerlach, 2016; Grundy, 2014).

The media focus relentlessly on the heroism of European and American responders and fell back on the stock images of Africans as helpless, hapless, victims who were nonetheless stubbornly resistant to Western medicine, irrationally carrying on with “secret burials,” and then getting on planes and spreading the disease to unsuspecting places like Dallas (Moran, 2015, p. 177)

The literature argues that the focus on Western heroism framed the outbreak as a narrative where Ebola started as an ‘African problem’ with racialized subtext and became a global threat (Moran, 2015; Nunes, 2016; Roemer-Mahler and Rushton, 2016). In this light, Western medicine, Western equipment, and Westernized behaviors are the solutions. Not only did it delegitimize local efforts to stop the disease spread, but it also largely ignored non-Western aid resources, such as those offered by China, Cuba, and Uganda. The aid from these nations was also vital and, in some cases, had responded sooner to West Africa than Western donors and humanitarians. This finding from the literature builds on Leach and Hewlett (2010)’s research on outbreak narratives.

5.2.3.1 ‘Cultural-related Problems’

According to Leach and Hewlett (2010), another narrative that developed to discuss prior Viral Hemorrhagic Fever (VHF) outbreaks, is one of “cultural knowledge”. This had been used by anthropologists, such as Hewlett and Amola (2003), Hewlett and Hewlett (2008), Parker et al. (2019), and Richards (2016) who have decoded and understood local beliefs and perceptions about illness broadly, and EVD specifically. These had the intention of explaining local behaviors and cultural rituals that were seen as ‘bizarre’ to Western responders and help adapt interventions into the cultural framework.

However, some literature use ‘culture’ in an oversimplified manner for a variety of factors in the demand-side challenges in a disease outbreak. For example, in Msyamboza et al. (2014, p. 723)’s research into repeated Cholera outbreaks in Malawi, the authors list several challenges as “sociocultural risk factors” like infrastructural barriers regarding clean water, such as not enough pipes, lack of a chlorinated system, or distance to a source of clean water. The cultural-related problems, which are learned behaviors or perceptions,¹¹⁸ were issues such as believing chlorinated water “tasted funny”, normalizing Cholera

¹¹⁸ There is not a singular definition of ‘culture,’ although this one is the most basic definition. See Baldwin et al. (2006), Birukou et al. (2013), Blumenthal (1940), and Harris (2001) for historical and multidisciplinary concepts of culture.

outbreaks, or believing in spiritual causes for the illness. The thesis holds that the first set of problems has to do with infrastructure, in other words, these problems have political and economic causes.

Another example is from Bulte, Richards, and Voors (2018)'s discussion of cultural and moral obligations. Families are obliged to bring food to sick relatives in the Ebola Treatment Centers (ETUs), but they were prohibited from entering the hospital grounds. There is also a structural reason why families do this: many health facilities in West Africa do not serve food. Hospital food is a Western luxury and patients must either purchase food from vendors outside the hospital or rely on relatives to visit and bring food. Or sometimes relatives need to purchase drugs or other equipment for the patient if the health facility does not have them.

Many ETUs were initially in urban areas, which made it difficult for people from rural hinterlands to access them. Some people had to travel hours (and sometimes days during the rainy season when dirt roads turn to mud) via motorbike, taxi, or private vehicle to reach one of these overcrowded centers. By then, not only could it have been too late for the patient, but his or her extensive travels may have exposed others to EVD. The logistical problem of aid not penetrating local communities could have been a factor in the choices of some affected people. For instance, burial teams were sometimes slow to respond, leaving some families with no choice but to conduct a funeral. A corpse sitting in the home or on the street for days could bring other health and sanitation problems.

Media and academic sources discussed the local population's widespread disbelief and denials about EVD being real, however, these sources attributed this to religion or lack of biomedical knowledge (Davies, Bowley, and Roper, 2015; Samb and Toweh, 2014). However, state institutions often broadcasted confusing and conflicting information or were slow to give information. Informants from both countries knew there was EVD in Guinea; and in Sierra Leone, many knew it was in Liberia at the time too. These issues carried over after the outbreak too; during fieldwork in Liberia, there were suspicious cases from the southeast region from funeral attendants. The ministry did not confirm any details reported in the newspapers and samples were sent abroad for testing (Front Page Africa, 2017). Information was vague, and newspapers only announced deaths and new cases. Several weeks later, the Ministry of Health confirmed that these patients had Meningitis. However,

many people were skeptical of the veracity of this information. This did not have to do with a lack of biomedical knowledge or religious belief but the skepticism of state institutions.

The literature sometimes discusses these ‘local problems’ and ‘bad behaviors’ without consideration of social, political, and legal structures and how this compares to other societies in a similar context. Sometimes doing this may help to avoid stereotyping or otherizing human subjects. These examples above show that there are factors beyond culture that should also be explored. There can be culturally-derived responses for structural problems, but sources do not always fully distinguish and analyze which problems are structural or cultural and how they impact each other.

By otherizing human subjects, the meaning and intent of people’s behaviors are not fully understood. For example, the literature focused on the community member’s fears of nefarious activities taking place in the health centers or sponsored by the government (Hogan, 2014; Mark, 2014; Schwerdtle, De Clerck, and Plummer, 2017; Wilkinson and Fairhead, 2017), without considering that the phrase, ‘injecting you with Ebola’ may also refer to nosocomial transmission, depending on one’s language skills. Otherizing not only make subjects appear ‘strange or odd’ but it also helps to discredit local responses to address a public health emergency. According to Jones (2011) ‘culture’ has been reconstituted as a risk factor in Ebola outbreak narratives, which hides political, economic, and/or structural challenges, such as why people avoid health centers. Past research showed that this may have saved lives if a clinic was the source of an outbreak due to poor sanitation practices. This is what happened in the 1976 EVD outbreak at the Yambuku Mission Hospital (Breman, 1978).

5.2.3.2 The Pattern of Discrediting Local Solutions

There is also a history of ignoring or discrediting local interventions in health for Western-derived solutions instead. Continuing with the example of the HIV/AIDS pandemic, funding to target this disease jumped to the billions in the 1990s after it was framed as a security issue (Benes, 2017). As discussed before, health security has been used as a justification for cooperation and sometimes, militarized interventions.¹¹⁹ However, local and inexpensive approaches, such as in Uganda, were largely ignored by international AIDS

¹¹⁹ In chapter one, page 43, it was briefly discussed that HIV/AIDS and EVD responses were securitized. This was part of an ongoing trend in global health that uses security to justify intervention, and sometimes, with military resources.

advocates, especially since it bypassed many Western-derived services (Benes, 2017; Mustapha, 2006). In effect, this is a hidden transcript (Scott, 1992) in the HIV/AIDS debate.

Another example to build on, are the industry solutions that seek to medicalize and standardize treatments in low-income countries, using oral rehydration therapy as an example (Werner and Sanders, 1997). The main treatment for diarrhea is consistent rehydration, as no drug can cure it. Development agencies such as the United Nations (UN) and the WHO commercialized and marketed expensive rehydration solutions created by pharmaceutical companies. They encouraged local communities to abandon traditional practices of food-based rehydration, such as blended cereals or porridges, and instead encouraged dependence on commercial oral rehydration packets promoting them as medicine. These commercialized packets were limited in rural areas or people had to buy them (Werner and Sanders, 1997). Standardizing and medicalizing solutions may inadvertently create dependency on Western-derived resources, which can be problematic in isolated communities. Therefore, during the Ebola outbreak, local institutional changes in rural communities were solutions to eradicate EVD.

Behavioral changes such as handwashing and enforcement strategies such as checkpoints, demonstrate internal institutional changes. This builds on previous studies' notion of institutional change and institutional quality as the result of a significant event (Baldwin and Mvukiyehe, 2015; Bellows and Miguel, 2009; Voors and Bulte, 2014). Local institutions amended religious rituals and cultural norms to fit the emergency context, largely in communities without much aid resources (Hagan et al., 2015; Parker and Allen, 2018; Parker et al., 2019). However, local solutions were fetishized in the public transcripts as 'secret burials,' 'bad behaviors,' or 'resistance' against government and aid workers (Boland and McKay, 2018; Cenciarelli et al., 2015; Fairhead, 2016; Fallah et al., 2016; Laverack and Manoncourt, 2016; Wilkinson et al., 2017; Wilkinson and Fairhead, 2017). For example, caregiving was made safer through improvising with the "garbage bag Personal Protective Equipment" (PPE) (Perry and Sayndee, 2017). Or a bamboo reed was used as a pipe to irrigate clean water for handwashing as mentioned in the member checking, in Appendix C. In these cases, the information needed was not biomedical content, but on how to protect oneself from EVD using the available resources (Abramowitz et al., 2015). Moreover, although this section discussed specific examples in health interventions, we can also see how this broadly builds on Hanlon (2012)'s critique of the good governance

framework in development policy. Demand-led interventions have always been viewed by Western development practitioners and donors as ‘poor governance.’ The next section explains how locally-derived solutions reduced the demand-side barriers in the market.

5.3 Market Approach of Locally-Derived Solutions

This section addresses the research objective: to identify challenges that hampered the management of Ebola identification and prevention at the local level. Some information failures in the market hindered the proper identification of Ebola patients. In addition, some behaviors such as avoiding health centers, movement between areas, and unsafe undertaking of corpses hampered prevention and containment efforts. This section provides an interpretation of the market failures during the outbreak. It first introduces the theoretical framework to explain how community and traditional leaders helped to correct some of these market failures. It then supports this framework by examining the market failures in the next two subsections: 5.3.2 and 5.3.3.

5.3.1 Theoretical Contribution to Knowledge

TlIs are the laws, norms, and behaviors that its members follow, and these institutions operate at the community level. The organizations of paramount chiefs, chiefs, clan leaders, councils, monarchs, youth leaders, and secret societies regulate these traditional norms and laws. Low transaction costs have defined institutional quality or good governance for economic growth (North, 1990; North, 1991; Pande and Udry, 2005; World Bank, 2002). Thus, this framework is narrowly applied to institutions that regulate the economy for economic change. This would exclude most rural-based institutions and instead focus on urbanized state institutions in a market-led growth model (Gray, 2016).

The reduction of social costs and the correction of information failures in the market can also be factors of high institutional quality. Thus, the theoretical contribution is that TlIs engaged during rulemaking, monitoring, and engagement strategies during the outbreak to reduce social costs and correct information failures, which demonstrates high institutional quality. Furthermore, the eradication of EVD and improved social outcomes have an impact on the economy too. At the end of the Ebola epidemic, measures restricting movement were lifted and production and trade recommenced.

However, this does not mean that local leaders were able to resolve all costs, as some challenges are not governed by them. For example, infrastructure is governed by state institutions or aid resources are governed by donors and nongovernmental organizations (NGOs).

5.3.2 Information Failures during the Epidemic

There were skepticism and disbelief when EVD was detected in a distant county or district in 2014. This was across all socioeconomic backgrounds and levels of education. Warnings and public health campaigns from MHSW in Liberia and MOHS in Sierra Leone, lost credibility when vague and sometimes conflicting advice was issued such as ‘stay away from *bushmeat*.’ Scientists believe that some species of fruit bats and primates may transmit EVD to humans (Marí Saéz et al., 2015; Pourrut et al., 2005; Pourrut et al., 2007; Preston, 2012; Taylor, Leach, and Bruenn, 2010); however, common wild game observed in both countries were snails, slugs, deer, and fowl (often called ‘country chicken’). None of these kinds of *bushmeat* have been thought to carry EVD. Therefore, many people were skeptical as the information did not match what was happening on the ground. After the index case in Guinea in December 2013, all transmissions since then were human-to-human (Richards, 2016). Consequently, EVD cases (patients) were coming into the health centers without a history of encountering or eating the believed dangerous *bushmeat*. This led health workers to set aside concerns that these were potential EVD cases and not wear PPE when caring for these patients. It is common practice to choose when to wear PPE, as these supplies were highly limited and had to be used judiciously.

Information on EVD also centered on hemorrhaging from bodily orifices (Dallatomasina et al., 2015; Richards, 2016). Thus, many health workers misdiagnosed EVD patients and consequently, this led to many deaths. Community members became fearful and mistrustful. Loved ones who were sick but did not show signs of unusual bleeding were misdiagnosed with Malaria or another common endemic disease. However, when these patients did not return from the health centers, it raised suspicions of nefarious activities or the perception of the low quality of care. Some people feared nosocomial infection of EVD since Infection Prevention Control (IPC) standards were not uniform across all centers. So, this information failure of EVD symptoms led to a social cost of misdiagnoses and community members avoiding the health centers.

Information on EVD focused on its deadliness, with informants saying they received information that it was lethal and incurable. Some also discussed witnessing health workers on their deathbeds. Therefore, journeying for many hours or days to reach an ETU or a large hospital was seen as a fruitless and costly endeavor by some. Many thought it was better to face what they thought was inevitable at home. These main information failures affected individual health seeking behaviors (consumers) and clinical management (health workers).

TLLs in Sierra Leone helped correct these information failures through engagement strategies, such as holding town halls with health workers and organizing health sensitization in the communities. The mandatory reporting and isolation bylaws made it necessary for all sick persons and visitors to go to the health centers, not just those who may think they have EVD. However, if a health worker is misinformed on how to properly diagnose the disease, it may still lead to a social cost. In Liberia, community leaders and volunteers conducted health sensitization, referral, and escorting of sick persons to the health centers too.

5.3.3 Social Costs and Negative Externalities

As explained in Reubi (2016), there is often an assumption that in a free and competitive market, consumers bear all the costs for their decisions. However, sometimes a choice creates costs that are absorbed by other individuals: a social cost. Early treatment of a VHF can increase chances of survival. If a person is admitted to a health center and receives care from clinical professionals in isolation, it also reduces the risk of spreading the disease to relatives or community members (Lokuge et al., 2016; Okware et al, 2002; Roddy et al., 2007).

However, those that did not seek treatment in this manner likely received care at home by family members, culminating grave risks of spreading EVD. The person is more likely to die incurring a private cost, but then family members are exposed to the virus too. In turn, family members also become ill, either one at a time or at the same time. At a macro level, this is a negative externality. This means that the social costs are greater than the private cost. Deciding to receive care at home, where family members may not wear PPE or are unskilled at wearing PPE may prolong the disease spread. Regulations and enforcement mechanisms, such as a community engagement strategy on contact tracing, are supposed to reduce social costs from a VHF outbreak, by monitoring and referring

affected individuals.¹²⁰ As stated above, traditional and community leaders organized and participated in contact tracing to refer all sick persons and visitors to a health center.

There were other social costs during the epidemic too. For example, some informants mentioned that health centers closed because health practitioners stopped working. Building from chapter one, health human resources (HRHs) have been very low since the end of the civil conflict (World Health Organization, 2012b). This is because the wars resulted in large displacement and expatriation of citizens, especially skilled professionals such as health workers. Nurses and doctors were the main victims of EVD, depleting an already scarce resource. In this case, the decision to stop working when HRHs were depleting is another social cost; some health centers closed down and the ones that remained open were overwhelmed. Bullard (2018) reports that a major NGO refused a financial donation and instead pleaded for more HRH volunteers to aid in the response, as capacity was needed and not money. Thus, this social cost had been difficult for traditional and community leaders to resolve as it is a supply-side barrier.

Another social cost was undertaking and funerals (Davies, Bowley, and Roper, 2015; Enria, 2017; Parker and Allen, 2018; Parker et al., 2019; Richards et al., 2015; Richards, 2016). Funerals were identified as high-risk events for transmitting the virus, as EVD is highly infectious on a corpse (Dallatomasina et al., 2015; Perry and Sayndee, 2017; Preston, 2012; Richards and Mokuwa, 2014). However, funeral rites in West Africa have a cultural and religious significance. Perry and Sayndee (2017) say these are communal gatherings as it is not an individual who arranges the ceremony but an entire family. Many families continued to bury their dead, whether in 'secret' to resist the ban or by violently keeping away burial teams and contact tracers (Wilkinson and Fairhead, 2017). Therefore, it seems that this social cost was largely due to cultural and religious factors, by people refusing to abandon their traditions. Bylaws banning funerals in Sierra Leone should have reduced this cost. However, there were other factors related to the environment and infrastructure that hampered efforts to reduce unsafe undertakings and burials, as explained below.

5.3.3.1 Infrastructure and Policies leading to Social Costs

¹²⁰ See section 2.6.2 on the dominant narrative of public health emergencies and how contact tracing efforts help eradicate a VHF outbreak.

The social costs of unsafe undertakings and burials are also linked to infrastructural and logistical problems during the Ebola epidemic. The literature explained some of the cultural and religious aspects (Richards, 2016; Wilkinson and Fairhead, 2017), but informants discussed that there were also state institutional failures that exacerbated this. Burial teams created to collect corpses and sometimes draw blood for testing were in low capacity. Corpses would sit in a home for days, despite calling the central hotline for a burial team. Thus, in the hot and humid rainy season during the height of the epidemic (April to August 2014)¹²¹ many families and community members felt that they had no choice but to give the deceased a proper burial. This state institutional failure would have undermined the ban on funerals passed by TLIs.

As mentioned above, it is a social cost if a suspected EVD patient did not go to the hospital as soon as possible; misinformation is partly to blame for these decisions, but so is the infrastructure of the healthcare system and protocols of some external partners. Perry and Sayndee (2017) say that some relatives were unwilling to bring their loved ones to the health centers in Liberia because these facilities were known to have poor infrastructures such as lack of running water and no food. It was a concern that a sick person would deteriorate under these conditions. Therefore, the thesis holds that avoiding the health centers was partly linked to the structural problems of an under-resourced healthcare system, which undermined the mandatory reporting bylaw or referrals and escorting done by community leaders. In addition, during the outbreak many hospitals prohibited family members from entering the grounds to bring food or check on their relatives' wellbeing. This also deterred referrals. However, in phase two, some donors and agencies changed this protocol to allow families to visit (Sharma et al., 2014).

Another example to build on is from Abramowitz (2014)'s discussion of structural problems in Liberia; relatives of the sick called the state-run Ebola hotline for an ambulance, but help only arrived to retrieve and bury the corpses.¹²² Resources may have been prioritized for safe burial management, rather than making ambulances available to transport sick persons and to staff local health centers. This is probably because funerals were classified as high-risk for EVD, and ETUs in urban areas were prioritized rather than

¹²¹ The rainy seasons are from the end of April to July and again from September to October. Most road networks are dirt roads and it is extremely difficult to travel as these roads become muddy. There is also a rise in Malaria infections as stagnant pools of water become breeding grounds for mosquitos and attract other vermin.

¹²² See this narrative discussed in chapter two, under section 2.7.1.

local centers. Thus, some aid interventions and policies may have hindered behavior changes, such as health seeking and resulted in undesired effects, such as at-home caregiving.

PPE and drugs were consistently in short supply, so health workers had to judiciously use them, even during the outbreak. Some health workers modified their methods to not touch patients but admitted in some circumstances it had to be done such as a weak or falling patient. Informants were knowledgeable on biomedicine and understood that PPE prevents infections. However, the lack of these supplies often means using resources very judiciously (such as making one box of gloves last three months) or taking a chance to treat patients without them. If a health worker did not feel there was a risk, she or he may decide not to use PPE, hence why understanding EVD is important. This finding contradicts the perception that healthcare workers in developing countries lack knowledge of IPC or biomedical science (Abdullah and Kamara, 2017; Dixon, 2014; Keneally, 2014). Access to PPE needs to be considered, when examining decision making and poor IPC standards. Poor IPC standard was a social cost that could not be addressed by community-level leaders.

The findings build on other research that shows community members did not comply with some control measures because of lack of trust of state institutions and not solely due to lack of biomedical knowledge (Blair, Morse, and Tsai, 2017; Boland and McKay, 2018; Morse et al., 2016; Vinck et al., 2019).¹²³ The challenges mentioned in this subsection are governed by state or aid institutions and demonstrate that these barriers had hindered some behavior changes needed to reduce EVD spread and deaths. Thus, even though traditional and community leaders organized and passed regulations and participated in community-led engagement strategies; barriers governed by state or aid institutions could have undermined their efforts. Hence why it is crucial to consider other bylaws (banning handshakes or secret society rituals) or other locally-derived solutions (safer burials and garbage bag PPE) that do not affect the demand for aid resources, but rather are institutional changes to prevent or stop EVD.

5.3.3.2 A Private Benefit leads to a Social Cost

¹²³ See Parker and Allen's response to the Boland and McKay (2018) post on the LSE blog, in the same url in Boland and McKay (2018).

Not all decisions or behaviors incurred a private cost to the individual. In fact, some behaviors incurred a benefit to the individual but still borne a negative externality to the wider community.

Many health workers discussed leaving the health centers and refusing to work, which left many facilities closed and unable to provide services. As explained above, this incurred a negative externality as patients had to travel farther to ETUs for care, or nonEbola patients did not receive care for their conditions (e.g. pregnant women about to deliver). However, considering the framework by Becker and Becker (1997) and Reubi (2016) on social costs, a surprising finding is that the health workers who decided to stop working did not incur a private cost.

An initial argument is that they lost a paycheck and therefore, were financially constrained, incurring a private cost. However, in this context, it is common for health workers to go months without a paycheck, and when one received remuneration, it sometimes did not come with back pay. Thus, it is difficult to argue that the health workers that stopped working were more financially affected than the ones that continued working. Rather, since health centers were also a source of EVD transmission (likely due to poor IPC), the thesis holds that those who stopped working and stopped risking their lives incurred a private benefit that came at a cost to the community.

Some institutional failures such as not paying employees may translate into higher incentives for individuals to inflict social costs, given that there are no private costs associated with them.

Sections 5.2 and 5.3 address the first research aim of the thesis. The first aim is to investigate the role of TLIs and community-level leaders during the epidemic in both countries. We identified the challenges that were not being addressed by state institutions and how traditional and community leaders supported efforts. This fulfilled both objectives under the first aim in these sections.

5.4 Governance of the Outbreak

This section addresses the first research objective under the second research aim: an examination of the narratives from health workers and community stakeholders regarding how the overall response governed the EVD outbreak. The first section presents the evidence-based contribution to knowledge, from the findings on how the EVD outbreak was

governed via a polycentric institutional response. Section 5.4.2 briefly recaps what polycentric governance is from chapter two. The remaining sections 5.4.3 and 5.4.4 present the evidence from each country on how multiple institutions governed and how this helped or hindered efforts to resolve the market failures.

5.4.1. Evidence-Based Contribution to Knowledge

The 2014 EVD outbreak was governed by multitier institutions that have their structures and regulations to address social problems. Using a market approach as discussed above, TLIs and community leaders can help overcome the challenges of trust, reputation, and legitimacy, which are demand-side barriers. These institutions are specifically tasked to address these issues and hence, were more effective at resolving information failures and social costs. Humanitarian and donor organizations were effective in governing the supply-side of the market, by bringing these tangible resources such as PPE, ambulances, fuel, drugs, funding, and HRHs.

This evidence is derived from the data, but a market approach makes some assumptions around the decision making of consumers (citizens) and producers (donors and NGOs). Interpretation of this evidence may oversimplify the governance challenges. For example, demand-side barriers can be due to environmental and infrastructural problems that hinder the efficient delivery of goods and services. Lack of strong road networks has been mentioned in the literature and interviews as challenges for external partners to reach remote areas and for community members to reach ETUs. Therefore, neither TLIs nor external partners are equipped to address this challenge, as it relies on state institutions, and it could still result in a market failure.

This analysis provides a relatively simple explanation for how rulemaking and monitoring changed behaviors in the community and the international response governed the supply of aid resources. However, the reality is more complex; rulemaking, monitoring, and enforcement were not effective everywhere, especially as communities organized differently in Liberia and there were some areas in Sierra Leone where some bylaws were not as effective.

5.4.2 Recap of Polycentric Governance

Building on chapter two,¹²⁴ polycentric governance is where institutions are designed at each level to meet specific governance challenges (Oström, 1990; Oström, 2010). This literature discusses polycentric governance for the communal management of resources as opposed to a market approach to manage them. Common goods are defined as goods that are rivalrous but nonexcludable (Brousseau, Dedeurwaerdere, and Siebenhüner, 2012).

This arrangement is different from the decentralization of command or resources. Each institution is responsible for commanding and securing resources to address challenges in its jurisdiction. These institutions are locally managed, have higher social capital, trusted leaders make the rules, and they live inside the affected communities and thus, will be affected too (Acheson, 2000; Oström, 1990; Oström, 2010).

Sawyer (2004; 2005b) argue that the Mano River region would benefit from peacekeeping and delivery of public goods with taskforces designed locally and across provincial lines. Moreover, these could add resiliency to national governing agreements and strategies. He says that social capital can mobilize people to self-govern. However, Acemoglu, Reed, and Robinson (2014) argue that social capital can have negative consequences for development such as patrimonialism.

The thesis holds that polycentric governance was observed during the 2014 EVD outbreak. The challenges of trust and legitimacy of state institutions were demonstrated in chapter one and the thesis builds on it by explaining how these led to demand-side barriers. In other words, state institutions were not able to affect behavior changes via decentralizing resources alone. For example, the Afrobarometer data show that local elected officials do not enjoy the same levels of trust and influence as traditional leaders (Afrobarometer, 2019).¹²⁵ However, while they prefer TLIs, this does not mean community members do not want reform of these institutions either (Sesay, 2019; Van den Boogaard, Prichard, and Jibao, 2019). Community members tend to identify their communities as part of a clan or chiefdom, and not always by the geographical demarcations where the state and external partners usually channel resources (Baldwin, 2015; Mulbah, 2018; Wilkinson et al., 2017). This may explain why sometimes aid and government resources do not penetrate the community. However, this does not mean that support for TLIs is a substitution for state

¹²⁴ See section 2.2.1 on polycentric governance.

¹²⁵ See Afrobarometer data listed in Tables 1.6 to 1.17 starting on page 33.

institutions, as prior research shows, both authorities must collaborate to bring stronger development outcomes (Baldwin, 2015; Van der Windt et al., 2018).

5.4.3 Organizing in Liberia

The types of organizing and engagement varied from community to community. Therefore, there were no consistent emergency management regulations from local institutions implemented throughout the country, except for the government's policies. If one neighborhood implements isolation, but someone becomes sick or dies and safe transport does not occur, then people are essentially quarantined with an active case. Likewise, door-to-door health sensitization may improve knowledge, but if an undetected case can enter or leave a neighborhood, then it is unclear how this alone affects EVD incidences on a broader scale.

Arguably, trusted and well-known leaders can implement systems that fit the local context, so having exact emergency procedures from community to community may not be necessary. For example, if a health center was closed in a remote village, then it may not make sense to have a mandatory reporting law. Rather, local leaders may prefer health sensitization and distribution of PPE to lower the risks of infection during at-home caregiving. Whereas another neighborhood that I visited in the field, was a mere walking distance from the county hospital. Therefore, local organizing efforts in that neighborhood focused on escorting sick persons to the hospital.

5.4.3.1 Challenges of Coordinating with External Partners

Community stakeholders described the partnership between local, national, and international actors as less cooperative than the health workers did. Informants started organizing before phase two and report not receiving assistance or supplies from donors or NGOs. Likewise, Kirsch et al. (2017) and Nyenswah, Engineer, and Peters (2016)¹²⁶ say that while supplies from donors were an important contribution, much of it was brought too little too late. The priorities of international donors¹²⁷ did not always match those of the government or local communities (Nyenswah, Engineer, and Peters, 2016). The findings support Kirsch et al. (2017)'s and Nyenswah, Engineer, and Peters (2016)'s research on

¹²⁶ Tolbert Nyenswah was appointed by President Johnson-Sirleaf to lead the central taskforce during the EVD outbreak.

¹²⁷ This article refers to all humanitarian, funder, and donor agencies as 'donors.'

leadership problems during the outbreak; and builds on chapter one's discussion of aid during the outbreak (Benton and Dionne, 2015; Kickbusch and Reddy, 2015; Moon et al., 2015).¹²⁸ Thus, the coordination of multitier institutions had some challenges that were political in nature. For example, Nyenswah, Engineer, and Peters (2016) discuss taskforce meetings in Monrovia where government officials had identified local community groups, such as a church conducting community engagement, but the donors declined to assist because these leaders were "unknown" to them.

The supply of aid resources and how these were channeled were impacted by political considerations and not necessarily finding the best mechanism to resolve demand-side barriers. Kirsch et al. (2017) and Nyenswah, Engineer, and Peters (2016) describe donors and NGOs as unwilling to relinquish control of supplies and sometimes not work alongside the centrally created taskforce (state institution). In a public health emergency, donors and humanitarians are sensitive to media coverage and want to be presented as one of the main responders. This can undermine strategies created by state institutions or community and traditional leaders to address the demand-side barriers.

5.4.3.2 Health workers' narratives: aid resources did help

This analysis of Liberia presents an interesting enigma. The health workers that were interviewed felt the supply of aid resources greatly benefited them; many returned to the health facilities once equipment, medicine, IPC training, and regular salaries were available. By the end of September 2014, Liberia had the highest HRH casualties, out of the three West African countries at the epicenter of the epidemic, with nearly 200 deaths of workers (World Health Organization, 2015c). So, some did not return to work and the ones that continued limited contact with patients and visitors. As explained above, this was a social cost that hindered EVD containment and aid helped to resolve these particular costs.

Since donors and NGOs were bringing clinical resources that are key to a biomedical strategy, it makes sense that health workers felt more positive of international aid than community stakeholders who are not clinical practitioners. However, informants did not discuss donors or NGOs as having strengths to address the demand-side barriers. Local leaders and volunteers were identified for doing so. Therefore, there was a polycentric

¹²⁸ See section 1.6.1 on supply-side challenges to the Ebola outbreak.

arrangement where aid was supplied by international actors and community leaders acted to address some of the demand-side barriers.

5.4.4 Rulemaking in Sierra Leone

Traditional and community leaders organized through legal authority and social capital. TLIs and leaders could not overcome some barriers, such as the slow response from the burial teams or poor IPC standards at health centers, which were partly responsible for the social costs. The common thread among all community stakeholders interviewed was that they felt the government's response was not effective and after witnessing the tragedies of the disease, they needed to act.

5.4.4.1 Deliberative Process and Social Capital

Enria (2017), Wilkinson and Fairhead (2017), and Wilkinson et al. (2017) say that local engagement strategies were not democratic and that the bylaws were passed in an authoritarian manner. It is interpreted that the authors believe the chiefs are undemocratic because they do not come into power through a liberal democratic election. However, they did not explore the deliberative democratic processes that are common in indigenous societies in West Africa or how chiefs remain accountable (Baldwin, 2015; Bulte, Richards, and Voors, 2018; Mulbah, 2018).

A limitation of the good governance framework is that it relies on short-term interest as a rationale for cooperation. An analysis is needed to understand why there is long-term cooperation in societies. Baldwin (2015) says that short-term election cycles can sometimes incentivize officials to create policies to promote him or her for the next campaign and not long-term policies to benefit the community. Thus, coming into power by an electorate does not guarantee accountability or good governance, but trust and delivery of public goods can be an indicator. However, patrimonialism as discussed by Acemoglu, Reed, and Robinson (2014) can create inequalities as those who are connected would benefit more from the unequal redistribution of goods or services. Building on this, we would expect that the chief (the one who initiated the bylaws) would have campaigned for more aid or public goods for his chieftom so that he could redistribute these resources via patron-client networks. Indeed, this would also fulfill short-term interests for cooperation. Instead, he gambled on his reputation to pass restrictive laws on people's intimate lives such as banning handshakes.

So how come this paramount chief had not decided to use his connections to bring an ETU to his town, as this may have also shown good will or score political points? Van der Windt and Voors (2020) say it is because TLIs live in the community and would be affected too, so they established bylaws. However, building on chapter one's discussion regarding the infrastructure of the health system and condition of aid resources (Herricks and Brooks, 2018), the findings show that the limitations of the health systems were well-known; people knew that NGOs were largely propping up the system and their aid was not sustainable.

There was a mistrust of state institutions and the health system. In terms of institutional response, his (the chief) experiences may have led him to decide to create emergency management rules as a more effective means to address the demand-side barriers instead of advocating for supplies alone. Therefore, only advocating for more aid would not have been good governance in terms of dismantling stigma or 'risky' behaviors.

5.4.4.2 Challenges in Polycentric Governance

Polycentric governance arrangements assume each institution can resolve a specific challenge. Thus, when delivering public goods and services, institutions at each level must interact and coexist effectively to address all aspects of a social problem.

However, political and logistical problems may have undermined cooperation between and even within institutions (McNeil Jr., 2014). For example, there were allegations of incompetence and corruption in state institutions, due to the failure to expedite donated supplies through entry ports. This was because of a disputed shipping fee of \$6,500 dollars (DePinto, 2016). This delayed some vital supplies from entering the country. Therefore, aid organizations are limited in addressing this barrier as the state is better positioned to resolve this. Additionally, some informants believed they would be paid during the outbreak, but some were not paid, and it was an external partner who advised against a salary for the health workers. TLIs have no control over this, and thus this policy may have created incentives for health workers to inflict social costs, by leaving the health centers and making the mandatory reporting bylaw less effective.

Although DePinto (2016) argues that corruption from domestic authorities hindered the distribution of aid resources, building from chapter two, we see that party politics and poor coordination between the government and international responders were also factors (Ross, Welch, and Angelides, 2017). Political in-fighting meant that some actors dragged

their feet to sabotage President Koroma's efforts, which also impacted the state and traditional institutions' effectiveness.

Likewise, not all traditional leaders felt that external actors had worked with them after phase two. Some NGOs entered and set up operations without alerting local authorities in Sierra Leone (Pedi et al., 2017). This not only undermined their authority but possibly hindered local coordination and engagement efforts too. Furthermore, not every area experienced a scaled-up response as aid resources were concentrated in the western and northern provinces and not where the epidemic began in the east (Boland and McKay, 2018; World Health Organization, 2014a).

When the bylaws were scaled up to a national strategy, state resources such as military and police personnel became available for monitoring and enforcement. Some informants say coordination with state institutions was effective, such as assistance with checkpoints and contact tracing. However, some also say that sending the military to enact isolation led to negative consequences in some communities as this did not consult with local stakeholders first. This builds on Enria (2017)'s findings on the use of state resources to enforce the bylaws. This could have been an ineffective arrangement between institutions in some areas if local stakeholders were not engaged first. However, it does not support that the use of the military was authoritarian as it will be discussed further below.

The evidence provides valuable lessons learned from this outbreak, specifically if community-level leaders are engaged in dialogue in order to coordinate with other actors. The final section examines these lessons for policy implications on future disease outbreaks.

5.5 Policy Implications

This section addresses the final objective under the second research aim: an examination of the literature regarding the community's impact on aid resources. Sections 5.4 and 5.5 address the second research aim: the links between community engagement and aid resources in a public health emergency. Informants from Sierra Leone and Liberia felt that local engagement efforts made a significant difference in stopping EVD transmission and deaths. Communities in both countries began acting independently before PHEIC in August 2014, and this diminishes the current narrative of the impact from donors and humanitarians. This raises questions regarding future outbreaks, such as how to create more integrative responses between international and local actors or whether aid was

helpful. However, no one that I spoke with thought that this should replace aid resources, even informants who were critical of the initial response. In fact, it was mentioned that the bylaws in Sierra Leone allowed workers and volunteers to do their jobs more effectively in terms of being able to enter communities safely.

5.5.1 Policy Contribution to Knowledge

There is a narrative that strengthening the health systems in West Africa and other low-income countries will help in emergency preparedness (Kentikelenis et al., 2014; Kickbusch and Reddy, 2015; O'Hare, 2015; Rabkin and El-Sadr, 2015; Vandi et al., 2017). The thesis does not argue against this lesson, but it also offers another lesson learned. Evidence-based findings of a polycentric response indicate that for future emergencies, domestic governments and local communities should aim to develop a multi-level institutional infrastructure to respond. This would not be done through vertical training. Each country, and communities within those countries, may already have something in place. Rather it should be a bilateral knowledge exchange to see what infrastructure exists and how domestic and international resources can support an active community-led response; instead of communities being expected to support a vertical response as discussed in chapter two (Lamunu et al., 2004; Okware et al., 2002; Roddy et al., 2007; U.K. Department for International Development, 2011).¹²⁹

The rationale behind this policy recommendation is to have local communities prepared to quickly mobilize resources to contain a suspicious disease outbreak at the epicenter. However, the unintended consequences may be in identifying those in the communities to lead the response. Ideally, community leaders should be identified in the field and internally within communities, rather than vertically by domestic governments or external partners. This would avoid having resented actors in charge as discussed by Wilkinson et al. (2017). If those who are in charge do not have the trust and legitimacy from the community, then they would be much less effective at bringing down the demand-side barriers in the next disease outbreak.

¹²⁹ Although the thesis observed supply and demand factors through community and international actors, the state is a central actor in all emergencies, especially as aid resources are channeled through this network. So, state institutions should engage in a bilateral knowledge exchange with local leaders to determine how aid resources should complement efforts.

5.5.2 Did the Bylaws Work?

As mentioned in chapter two, there is a debate on whether the bylaws in Sierra Leone were an effective response during the EVD outbreak.¹³⁰ Local community engagement efforts were discussed using Scott (1992)'s concept of hidden transcripts because the dominant narrative in the academic and gray literature depicts a donor or humanitarian agency as the central actor channeling clinical resources through government ministries to resolve supply and demand-side barriers. If community stakeholders are mentioned, they are seen being trained for engagement efforts (Centers for Disease Control and Prevention, 2007; Fallah et al., 2016; Georges et al., 1999; Lokuge et al., 2016; Muñoz, 2017; Okware et al., 2002; Onyango et al., 2007; Roddy et al., 2007; U.K. Department for International Development, 2011; World Health Organization, 2007; World Health Organization, 2009; World Health Organization, 2014a). This hidden transcript on the bylaws challenges the conventional knowledge that Western-derived aid resources are effective on their own in such public health emergencies.

The hidden transcript emerging from the findings reveal that a paramount chief from the Kailahun district initiated a collective action with other chiefs, traditional authorities, and health workers to mobilize an emergency management response (Richards, 2016). To the contrary, a WHO report (a public transcript) says that it was an NGO and WHO-led district taskforce that recruited community stakeholders and the paramount chiefs to “kick EVD out of the district” (World Health Organization, 2014a). It also claims to have mounted a response when it was first notified of EVD in West Africa, before declaring a PHEIC (Ippolito, Di Caro, and Capobianchi, 2015). However, the agency was heavily criticized for a slow response (Moon et al., 2015). The WHO Director-General maintained that the WHO was not an emergency response agency when defending the agency's intervention timelines (Fink, 2014). It appears that this narrative is an attempt to both deflect responsibility and take credit for declining EVD cases at the same time. It is a fact, however, that those EVD cases were already declining before the WHO officially intervened (Kouadio et al., 2015; World Health Organization, 2014a). The thesis holds that this is thanks to the bylaws implemented by traditional authorities in Sierra Leone and community leaders organizing in Liberia.

¹³⁰ See chapter two, sections 2.7.3 and 2.7.4.

5.5.2.1 *The Governance of Chiefs*

The thesis builds on the literature of how chiefs are governing for social or economic outcomes (Acemoglu, Reed, and Robinson, 2014; Baker, 2007; Baldwin, 2015; Beekman, Bulte, and Nillesen, 2013; Beekman, Bulte, and Nillesen, 2014; Casey, Glennerster, and Miguel, 2012; Dia, 1996; Pande and Udry, 2005; Sesay, 2019; Tokpa and Yengbeh Jr., 2012; UNDEF, 2014; Unsworth, 2010). It further develops the arguments that support for traditional leaders rely on cultural and religious legitimacy (Adjei, Busia, and Bob-Milliar, 2017; Fanthorpe, 1998; Fanthorpe, 2001; Fanthorpe, 2006; Logan, 2013; Sesay, 2019; Ubink, 2008). The thesis does not disagree with the premise of this argument, although cultural and religious authority varies from state to state and within states. The literature has largely confined traditional leaders as having authority over customary law (Adjei, Busia, and Bob-Milliar, 2017; Bulte et al., 2013; Castillejo, 2009; Fanthorpe, 2001; Fanthorpe, 2006; Khan and Mehmood, 2016; Mamdani, 2001; Richards, 2005; Sawyer, 2008; Seidler, 2014; Severeid, 1993; Ubink, 2008). However, their powers and jurisdiction are more broadly defined and they do act on behalf of state institutions, for example, to collect taxes (Chieftaincy Act, 2009; Local Government Act, 2015; Local Government Act of 2018, 2018; The Local Government Act, 2004). Thus, the demonstration of emergency management regulations builds on this argument too.

The findings show that cultural and religious foundations are only the beginning of understanding the authority of traditional leaders in this case study and across the region. As explained in section 5.2.3, 'culture' is used in some public transcripts as vague explanations for locally-derived solutions without always considering overall political, economic, and structural factors. And in some public transcripts on public health emergencies, these leaders are broadly lumped into a stakeholder category with few details on how they were engaged in emergency management (Centers for Disease Control and Prevention, 2007; Enserink, 2005; Lamunu et al., 2004; Roddy et al., 2007). In this case, they are seen as cultural interpreters or cultural mediators, placing the onus on select persons to 'demystify' local customs that seem 'odd' to responders or to change cultural practices to create a demand for aid resources. While the findings showed that local institutions did change behaviors to increase demand (such as mandatory reporting) other bylaws or solutions that were not directly connected to the demand for aid, helped to prevent EVD

too. These were institutional changes (e.g. banning secret society rituals, freedom of movement, and funerals, limiting *okada* drivers, garbage bag PPE, mandatory handwashing).

5.5.2.2 Authoritarian or State-Captured Response

Enria (2017) argues that the bylaws were not effective everywhere and often contributed to mobilizing authoritarian structures, such as the military. It is not clear from the findings how often police or military resources were used, except for some informants who mentioned violations or seeing military presence at checkpoints. State resources, such as the military and police were made available after the President's emergency declaration. This is a common protocol when a national emergency is declared in Western countries too (Reich, 2002; Relyea, 1976). For example, the 2005 Hurricane Katrina was declared an emergency and the National Guard (a military branch) was mobilized (Davis et al., 2007) and such resources were also available for public health emergencies in the United States too (Executive Office of the President, 2009; National Vaccine Information Center, 2009; Starr, 2009). In addition, emergencies were declared for desegregation efforts to keep order.¹³¹ So, it is unclear why these enforcement mechanisms are authoritarian in West Africa's context if they are consistently used in Western societies too. Or if this means that generally, military interventions in an emergency are authoritarian.

The thesis' message is not a call for more military intervention, as securitizing health can be problematic too (McInnes, 2016). The reliance on security to justify cooperation reduces humanitarianism to a lesser priority. Additionally, military personnel may not have experience conducting health interventions, and may sometimes provide poor quality of care (Davies and Rushton, 2016). But what transpires in public health emergencies is that the public transcript is predominantly used to feature Western heroism, and it also ignores or marginalizes efforts by local volunteers. For example, McMahon et al. (2017)'s study in multiple districts where community members took turns to man checkpoints or other activities to enforce the bylaws.

¹³¹ The United States has a long history of legal segregation, and in the 1950s when school districts began to integrate (bussing Black children to all-White schools), these schools, and often the Black children were targets of angry mobs, violence, and harassment. So, emergency declarations were made so that the National Guard would come and keep order. Often, the local police force would not have the resources to do so or perhaps the officers were compromised (meaning they were White supremacists too). See Drone (2005), Edelman (1973), Gordon (1994), and McMillen (1971) for further reading. Today, some school districts are still integrating, but this level of violence to declare it an emergency does not often occur.

Another argument against the bylaws is that the chieftaincy can be subject to state capture, meaning the bylaws may be an extension of the state's will (Wilkinson et al., 2017). At the time, the ruling party was the All People's Congress (APC), which had historically been less supportive of TLIs as a political institution (Harris, 2013; Tangri, 1980). Considerable violence had been used in the past to convert or oust chiefs who would not switch their allegiance to the ruling political party. This strategy went as far as banning local governments (Harris, 2013). While this does not refute the argument of state capture generally, a closer examination of the political and social relations between TLIs and the state is needed to explore if this phenomenon of rulemaking had been captured by state institutions. It is not clear what the incentive would be for chiefs, especially those favoring the opposition party during an election cycle, to implement the incumbent's mandate.

Thus, as mentioned in chapters one and two, identity politics is a staple in Liberian and Sierra Leonean politics. There were also some missteps mentioned by informants such as the (APC) minister sending troops to the Eastern region without consulting local stakeholders. However, while much had been speculated in the past regarding ethno-regional tensions in Sierra Leone and how this would affect collaboration of community-level and state institutions (Bellows and Miguel, 2009; Hanlon, 2005; Harris, 2013; Richards, 2005). The bylaws that started in the Mende chiefdoms transcended identity politics.

5.5.2.3 Two Bylaws

The public and hidden transcripts narrowly examine two controversial bylaws: the ban on funerals and that on at-home caregiving. The dominant narrative is that these activities are risky behaviors that spread EVD, or in other words, 'bad behaviors' (Boland and McKay, 2018; Carter et al., 2017; Dietz et al., 2015; Enserink, 2005; Lokuge et al., 2016; Maxmen, 2015a; Richards, and Mokuwa, 2014; Roddy et al., 2007). However, the findings show that several behaviors were adapted under the bylaws to prevent EVD such as handwashing, curfews, limited movement, no touching (including handshakes), and the ban on some secret society rituals such as genital circumcision. Most of the bylaws were still in place during fieldwork in 2017 and health workers noted that these continued practices were also decreasing other health problems, like diarrhea and Cholera. The narrow focus on these two bylaws painted broad narratives across the transcripts. For example, religion and superstition trumping over Western scientific knowledge (Gerlach, 2016); community

resistance to structural violence and international responders (Wilkinson and Fairhead, 2017); or that the entire strategy was ineffective and demonstrated poor governance (Boland and McKay, 2018; Enria, 2017; Wilkinson et al., 2017).

Abramowitz et al. (2015), Parker and Allen (2018), Parker et al. (2019), Perry and Sayndee (2017), Richards (2016), and Van der Windt and Voors (2020) broadly argue that local communities used local knowledge in the hidden transcript, but like the authors of the public transcript they focus on the concepts of funerals and caregiving and how they were made safer to reduce EVD. Handshaking and greeting in West Africa has a cultural significance and transmits the virus just as easily too, but this example was not used to discuss the effectiveness of the bylaws or people's science (Connolly, 2015; Doyle, 2014). Other behavior changes like movement, rituals, or handwashing that the findings show helped to reduce EVD cases, were also not fully explored in the literature. The hidden transcripts could have expanded their argument on a people's science if these had discussed the bylaws more holistically and comprehensively at impacting all behaviors, and not just two.

5.5.2.4 More Aid Can Help

The public transcript not only claimed that local response efforts were ineffective or poorly governed, but also that aid resources substituted these governance institutions (Boland and McKay, 2018). The public transcript calls for more aid resources in public health emergencies without considering that this contradicts the long-term goals of development aid initiatives to build self-sustainable systems. Thus, the public transcript is unclear on how aid can substitute poor governance while arguing that aid resources resolved the outbreak.

As discussed in chapter two, there have been several case studies that created community development committees to improve community participation and local governance. These have had mixed results, but the goal was to improve governance, which was defined differently in each study (Casey, Glennerster, and Miguel, 2012; Chhibber, Laajaj, and Bain, 2006; Fearon, Humphreys, and Weinstein, 2009; McMahan et al., 2017; Voors and Bulte, 2014). In some cases, we did see TLIs involved to expedite development projects (Casey, Glennerster, and Miguel, 2012) or pass bylaws for health governance (McMahan et al., 2017). The thesis holds that the paramount chiefs in the eastern provinces of Sierra Leone, who enacted emergency management regulations soon after the first case

was identified in the country, or community organizers in Monrovia conducting door to door distribution of buckets, are indicators of governance, response, and accountability. However, some of these efforts were hampered by external actors not contributing their resources towards it. This may be because donors were unwilling to relinquish control of their resources (Kirsch et al., 2017; Nyenswah, Engineer, and Peters, 2016). Furthermore, findings show that governance failures cannot always be assumed to be institutional failures of TLIs, rather there were logistical and infrastructural barriers that may have reduced the impact of the bylaws (for example closed health centers or slow burial teams). Therefore, this underlines the need for bilateral knowledge exchange in future outbreaks.

While any country would have struggled to contain EVD in an outbreak of this size and would also need external assistance; the public transcript on this outbreak marginalized the efforts of local actors and elevated the impact of external actors (Cenciarelli et al., 2015; Dhillon and Kelly, 2015; Elemuwa et al., 2015; Fallah et al., 2016; Fu, Robertson, and Burnham, 2015; Hagan et al., 2015; Laverack and Manoncourt, 2016; Lokuge et al., 2016; Olu et al., 2016; World Health Organization, 2014a).

Although this section focuses on Sierra Leone, as discussed in chapter two, this is a trend in the literature on public health emergencies (Allaranga et al., 2010; Centers for Disease Control and Prevention, 2007; Cohen, 2018; Enserink, 2005; Georges et al., 1999; Ilunga Kalenga et al., 2019; Lamunu et al., 2004; Médecins Sans Frontières, 2018a; Médecins Sans Frontières, 2018b; Médecins Sans Frontières, 2019; Moran, 2018; Msyamboza et al., 2014; Muñoz, 2017; Nkengasong and Onyebujoh, 2018; Okware et al., 2002; Onyango et al., 2007; Roddy et al., 2007; U.K. Department for International Development, 2011; World Health Organization, 2007; World Health Organization, 2009).

This trend continues, as this statement from the WHO summarizes who the key actors were at resolving one of the EVD outbreaks in the Democratic Republic of Congo in July 2018.

The outbreak was contained due to the tireless efforts of local teams, the support of partners, the generosity of donors, and the effective leadership of the Ministry of Health. That kind of leadership, allied with strong collaboration between partners, saves lives," said Dr. Tedros¹³² (World Health Organization, 2018e, p. 2).

Thus, a public transcript on the 2014 EVD outbreak would not examine local self-organizing as a central effort to eradicate a disease, as the thesis does below.

¹³² Dr. Tedros Adhanom Ghebreyesus is the current Director-General and the first African person to lead the WHO.

5.5.2.5 Outcomes: The Secondary Data

In past interventions, contact tracing was crucial to finding hidden cases in the communities and monitoring them for symptoms, early treatment can improve chances of survival from EVD (Okware et al., 2002; Pourrut et al., 2005). Therefore, a review of the new cases and death figures provided by the WHO may shed light on how effectively each country was able to mobilize and find hidden cases.

According to the WHO's Ebola situation report, West Africa was declared Ebola-free by June 2016, with a minimum of 42 days of no newly reported cases (World Health Organization, 2016d). Sierra Leone reported 14,124 total cases and 3,956 deaths and Liberia reported 10,675 cases and 4,809 deaths due to EVD during the entire outbreak period (World Health Organization, 2016a). The death ratio in Sierra Leone was 28%, while in Liberia it was 45% of EVD cases, according to these figures provided. Sierra Leone identified more EVD cases than Liberia, at almost 4,000 more new cases, but it recorded nearly a thousand fewer deaths than Liberia (World Health Organization, 2016a). Additionally, Sierra Leone was the first in the Mano River region to be declared and remain free of EVD through the end of the outbreak, whereas Liberia had to be re-declared four times, because of discoveries of hidden EVD cases (Bullard, 2018; World Health Organization, 2016d). I interpret that these results are due to Sierra Leone's nationalized organizing strategy to go door-to-door to find hidden cases. However, this strategy was built on the bylaws that mandated referrals and isolation and were enforced at the community level by TLIs and community stakeholders. Additionally, a legal strategy was not the sole manner behind the paramount chiefs' response, such as local institutional changes. Traditional leaders participated in other efforts too, such as reintegrating EVD survivors in the communities and social capital was used to legitimize the response efforts and engage the community.

5.5.3 Implications for Aid

The public transcript is dominated by narratives from Western volunteers and aid resources, who worked during the EVD outbreak (Bullard, 2018; Walsh and Johnson, 2018). However, non-Western aid resources or actors have not gotten this same level of attention, including those who died in this humanitarian effort (Agaba, 2014; BBC News, 2014; Daily Observer, 2014; Green, 2014; Schubert, 2014). Donors and NGOs are sensitive to how they

are perceived in a high-profile case, as Boland and McKay (2018) indicated regarding the lack of the responders' perspective in Parker and Allen (2018)'s fieldwork on community engagement. On the one hand, a narrative that does not feature the external actor as central to these engagements may lead funders and donors to ask why they are supporting these NGOs. However, by marginalizing the responses of local communities, we risk ignoring the challenges of integrating a multilevel response. Take for example, the recent EVD epidemic in the Democratic Republic of Congo and the failure to contain and eradicate the disease, despite the fact that this country has had repeated outbreaks of EVD (Beaumont, 2019; Ebola Gbalo Research Group, 2019; Vinck et al., 2019; World Health Organization, 2019b).¹³³ These are not solely the obstacles of biomedical knowledge or cultural practices. Indeed, in Parker's and Allen's response, they say that there have always been challenges in integrating international, national, and local efforts (Boland and McKay, 2018).

Thus, the implications from this research are that aid resources are ineffective on their own at resolving public health emergencies such as the 2014 Ebola outbreak, and that future responses need to penetrate and engage communities if the demand-side barriers are to be brought down. The thesis demonstrated that failing to follow such guidelines may mean international responses are not only less effective but also potentially damaging to local efforts, something which would lead to the imposition of high social costs.

5.6 Summary

This chapter brought together the findings and literature to have a comprehensive discussion of the theoretical and empirical knowledge of the case study. It began by understanding the informants' perceptions of state institutional failures and the international community's response. We learned that perceptions of institutional failure were not just about the delivery of resources, but also accountability, leadership, and trust, hence the lack of social capital and breakdown of social cohesion. Locally-derived solutions addressed some of these issues via interventions from traditional and community leaders. This finding builds on Acemoglu, Reed, and Robinson (2014), Baldwin (2015), and Bulte, Richards, and Voors (2018) on the role of social capital to legitimize response efforts. Hence, a surprising finding was that health workers were legitimized via local efforts to report and

¹³³ The EVD outbreak in the Democratic Republic of Congo was announced in August 2018 and was declared a PHEIC in July 2019.

escort people to the health centers for screening. This was not examined before (Parker and Allen, 2018; Parker et al., 2019; Richards, 2016). Furthermore, it builds on Hewlett and Hewlett (2008)'s research on communities self-organizing during EVD outbreaks and the research from Abramowitz et al. (2015), Pailey (2017), and Parker et al. (2019) on communities' responses due to aid and state institutional failures. This section also discussed how locally-derived solutions are portrayed in mainstream academic and gray sources, depicting these as cultural oddities or discrediting them; this builds on Leach and Hewlett (2010)'s research on outbreak narratives.

The next section 5.3 was the market approach of what prevented the identification and containment of EVD and how community-level institutions addressed these market failures. However, some market failures were created by the weak infrastructure. For example, in areas where burial teams could not respond in a timely fashion, this left no choice for community members except to bury the deceased, despite knowing the risks of EVD. Thus, local institutional interventions were limited in addressing some of the demand-side barriers. However, high institutional quality was demonstrated through the reduction of information failures and social costs, where changes in health seeking behavior led to a higher demand for aid resources, or in some places, institutional changes led to safer behaviors such as banning secret society rituals.

A surprising finding was that some policies or failures by state and aid institutions imposed high social costs by eliminating private costs. For example, not paying health workers led some to leave their centers, especially since the risk of getting EVD was high. This would have undermined efforts by traditional and community leaders to refer sick people. Funerals were prioritized as 'high-risk', which eventually led to more resources into creating burial teams, but not safe transport of the sick or to staff rural health centers; since the ETUs were in urban areas and therefore attracted local human resources.

Section 5.4 discussed governance of the epidemic with multiple institutions. It presented polycentric governance (Oström, 2010; Sawyer, 2004), as an evidence-based finding of how the epidemic was governed with a market approach of supply and demand factors. It concluded that external partners had strengths in governing the supply-side of the market and community-level leaders had strengths in governing the demand-side barriers. However, there were instances of tension that prevented both sides from fully integrating, such as donors' control on resources and sensitivity to how they are perceived in the media

(Nyenswah, Engineer, and Peters, 2016). Additionally, there was political infighting and corruption within state institutions (Ross, Welch, and Angelides, 2017). And as mentioned above, some policies undermined community-led strategies and inflicted social costs.

In the case of traditional leaders, this finding of emergency management regulations and bottom-up rulemaking builds on the literature regarding the role and powers of chiefs, which has mainly been confined to customary law and courts (Adjei, Busia, and Bob-Milliar, 2017; Bulte et al., 2013; Castillejo, 2009; Fanthorpe, 2001; Fanthorpe, 2006; Khan and Mehmood, 2016; Mamdani, 2001; Richards, 2005; Sawyer, 2008; Seidler, 2014; Severeid, 1993; Ubink, 2008). Hence, demonstrating the broad powers of TLIs and how they are governing in a progressive context.

This chapter finished its discussion with two policy implications that this research and others have speculated. The first was, whether aid was effective at all and should it be used in future outbreaks? The findings do not show that aid resources were negative; however, the conclusions were that the international response did not fully integrate with domestic strategies, which builds on Parker and Allen (2018) and Parker et al. (2019) arguments on aid. Health workers had a positive perception of donors and NGOs as suppliers, rather than with community engagement. The second implication was on how traditional and community leaders can be engaged in the future or even in other countries where their governance and influence may vary. The research found that legal management was not the sole manner of how paramount chiefs responded. Many participated in community engagement and education efforts too, using social capital to legitimize response efforts and the reintegration of EVD survivors. Thus, a bilateral knowledge exchange is needed between community and national leaders to develop an infrastructure that will address the demand-side barriers and can be complemented with supply-side interventions in future outbreaks.

CONCLUSION

In 2015, I first developed this project in New York City with several questions on the world's largest Ebola Virus Disease (EVD) outbreak and on the broader health status in West Africa. I started investigating what led to an epidemic of this size despite the countries being recipients of aid and health interventions for decades. In those days, I was a “consumer of knowledge” listening to “an existing conversation” (Single, 2009), by reviewing the extant literature and observing the exchanges between scholars, advocates, and other writers in the field. However, through the process of research and carrying out fieldwork for this Ph.D., I contributed to the conversation by answering the following question: what were the parallels and differences in how Liberia and Sierra Leone managed this outbreak? As described in the introduction, the two aims and four objectives answer this overall research question.

This conclusion chapter reviews the research findings and briefly revisits the key debates on traditional local institutions (TLIs), which are the norms and customs that are governed by traditional leaders termed paramount chiefs, chiefs, clan leaders, councils, monarchs, youth leaders, and secret society leaders; and good governance to highlight the significance of these findings and their implications for future outbreaks and interventions.

I. Summary of the Research Findings

The findings show that community-level leaders addressed governance challenges before the international community intervened in the 2014 Ebola epidemic in Liberia and Sierra Leone.

This was done to prevent EVD in communities that did not have it yet (such as a community in Bo District, Sierra Leone), or to stop the disease outbreak in affected areas (e.g. Montserrado County, Liberia). This was done because the perception was that the state and humanitarian responses were slow or ineffective. In Sierra Leone, the bylaws and door-to-door contact tracing were scaled up to a national strategy, where traditional leaders monitored and enforced the same rules and state resources were provided to help with this. In the end, Sierra Leone found 25% more EVD cases but had 18% fewer EVD deaths than Liberia (World Health Organization, 2016a). Additionally, Sierra Leone stopped the outbreak earlier in March 2016, whereas Liberia went into June 2016 due to repeated hidden EVD cases (World Health Organization, 2016d).

These findings challenge the mainstream literature on the 2014 Ebola outbreak, where aid organizations are featured as the lead actor in resolving supply and demand-side barriers (Cenciarelli et al., 2015; Dhillon and Kelly, 2015; Fallah et al., 2016; Fu, Robertson, and Burnham, 2015; Hagan et al., 2015; Laverack and Manoncourt, 2016; Lokuge et al., 2016; Sharma et al., 2014); often, ‘recruiting’ key stakeholders to help implement their intervention strategies. The supply-side of the aid market is tangible resources that is needed during an outbreak, in this case medical equipment, drugs, building mobile treatment centers (called ETUs), or shoring up health human resources (HRHs) through volunteers or capacity building. The demand-side of the market are local cultural or environmental factors. Sometimes these factors (called barriers) can affect the supply of aid resources.

It was community and traditional leaders that helped to correct the demand-side barriers of the market, demonstrating high institutional quality or good governance. The evidence suggests the outbreak was governed via multitier institutions addressing specific challenges such as supply-side barriers, logistics, or demand-side barriers. Thus, since local institutions can improve social outcomes by correcting the demand-side barriers, it makes sense to engage them in future disease outbreaks.

A. Originality of the Research

This thesis created a new evaluation metric for the known concept of institutional quality. As discussed in chapter two, this was conceived by North (1981; 1989; 1990; 1991; 2003) as a determining criterion of why economies grow, stagnate, or decline. It framed the World Bank’s development policies on good governance and economic growth for nearly two decades (World Bank, 2002). However, it has been argued that the indicators used for measuring institutional quality are narrow (Gray, 2016; Rodrik, 2004). Rodrik (2004) says that these indicators tend to favor the perceptions of investors, who generally feel positive when the economy is doing well. This often leads to the conclusion that high institutional quality is when investors feel private property rights are protected or the rule of law is upheld. However, we do not know which rule of law specifically or what the intended outcome of said law is. Additionally, Gray (2016) argues that the indicators, the protection of property rights and low transaction costs, specifically follow a capitalist growth pattern.

This would leave out economies that are not market-based and other institutions within capitalist economies that are not designed for capitalist economic growth, such as TLLs.

Therefore, the thesis redefines institutional quality in order to examine how community-level institutions govern and their outcomes. Two proposed indicators introduced into the framework were discussed in chapter two, section 2.5: social cost and information failure (Becker and Becker, 1997; Jha and Chaloupka, 2000; Reubi, 2016). Still using a market approach of supply and demand factors, when these market inefficiencies are high, then regulatory intervention can help to lower them and improve social outcomes. Additionally, some of these outcomes can also affect the economy. Thus, we applied these theoretical concepts to the empirical debate of local governance during the Ebola outbreak in Liberia and Sierra Leone in chapter two, section 2.7 and were further elaborated in the findings chapter.

During the Ebola outbreak, the literature discussed a host of information failures that affected consumer behavior (Perry and Sayndee, 2017; Richards, 2016). For example, state authorities initially banned the consumption of *bushmeat*, because international guidelines stated it could be a source of infection (World Health Organization, 2019a). While this information is theoretically correct, it did not fit the local epidemiology, hence an information failure. EVD was spreading human-to-human (Richards, 2016), and the type of *bushmeat* consumed in West Africa is not known to transmit this virus.

As discussed by key informants, confusing or vague information that did not match what community members saw, led to high social costs. In this case, a social cost is a death. Essentially, many people who did not consume or encounter *bushmeat* became very ill and died; while others who did eat *bushmeat* were fine. This made some people believe that the EVD outbreak was a hoax or that the healthcare system was unable to address the causes for the mysterious illnesses. Consequently, many people avoided the health centers, choosing to be cared for at home. However, home care is very risky if the caregiver does not have proper training and equipment. Many people died at home and consequently, other family members became infected and died too.

In Sierra Leone, systematic regulatory intervention came from traditional leaders who govern institutions such as customary law. A set of bylaws were passed as emergency management to help reduce social costs during the disease outbreak. These included but are not limited to: mandatory reporting of sick persons, quarantine measures, banning of

funerals and at-home caregiving, curfews, suspending blood rituals of secret societies, mandatory handwashing, and no contact with others. Additionally, traditional leaders organized townhalls and health sensitization campaigns to discuss the outbreak and give updates as needed, hence addressing information failures too. In Liberia, traditional and nontraditional leaders also intervened to help reduce these market inefficiencies. However, this was not systematically implemented nationwide like Sierra Leone.

This research contributes to two major debates regarding traditional leaders and institutions. A long-standing theoretical debate on the governance implications of traditional leaders and their role vis-à-vis the state; this is briefly revisited in section II. And an empirical debate of their role and impact during the 2014 Ebola outbreak; this is revisited in subsections B and C below on how the research aims were achieved for this study.

This theoretical contribution to knowledge achieves the first aim of the research question also discussed below in subsection B. This is the building block to our second and third contributions of this thesis. Considering that we developed this new concept of institutional quality, we observed in the data (i.e. key informants' interviews in chapter four) how TLIs governed during the outbreak and their relationship with state and aid institutions (the evidence-based contribution of polycentric governance). Next, we learned from these observations on how future disease outbreaks can be governed, especially in a low-resource context (policy contribution to knowledge).

In sum, the thesis holds that TLIs do exhibit good governance when addressing specific challenges that they are originally designed for: maintaining the social welfare of the community.

B. The First Aim: TLIs Governed the Local Community Response

The first aim was to understand the role of TLIs and community leaders during the 2014 EVD epidemic. This aim was achieved through a theoretical contribution to knowledge on extending the framework to add social cost and information failure as demand-side barriers.

The literature from chapter two discussed the demand-side barriers in identifying and containing the disease (Abramowitz et al., 2015; Cenciarelli et al., 2015; Davies and Rushton, 2016; DePinto, 2016; Enria, 2017; Kamradt-Scott, 2016; Parker et al., 2019; Richards, 2016; Van der Windt and Voors, 2020; Wilkinson et al., 2017). The informants'

interviews built upon what was discussed in the literature (for example, misinformation about EVD, losing trust in government agencies, and self-organizing to stop EVD), and adding what was not previously mentioned in the literature of locally-derived solutions. When I conducted fieldwork in 2017, many of the bylaws in Sierra Leone such as handwashing at public facilities, a 10 p.m. curfew, cessation of market/commerce on Sundays, and prohibition of some secret society rituals were still in effect. The literature had not previously investigated whether all these behavior changes helped to reduce social costs, because the focus was on two specific bylaws: banning funerals and at-home caregiving. These two bylaws directly affected the demand for aid resources. Therefore, the literature on the outbreak did not fully consider how locally-derived solutions were effective. Other bylaws that do not impact aid resources, such as handwashing or the secret society rituals, are institutional changes.

Traditional and community leaders helped to correct the market failures. However, these leaders were not able to address all aspects of the outbreak, because their strengths in governing were in the demand-side challenges. This leads us to the second aim of understanding how community, state, and aid institutions interact with each other.

C. The Second Aim: Multitier Institutions Governed Specific Challenges

The second aim was to understand the links between community engagement and aid performance during a public health emergency. This aim was achieved through an evidence-based contribution to knowledge. Thus, building on our theory of how TLIs governed the demand-side barriers; we observed how multiple institutions governed supply and demand-side challenges together.

The literature from chapter two, section 2.6, shows international responders and government agencies as lead actors in resolving these crises (Centers for Disease Control and Prevention, 2007; Georges et al., 1999; Médecins Sans Frontières, 2018a; Médecins Sans Frontières, 2018b; Médecins Sans Frontières, 2019; Muñoz, 2017; Okware et al., 2002; Roddy et al., 2007; U.K. Department for International Development, 2011; World Health Organization, 2007; World Health Organization, 2009; World Health Organization, 2012a; World Health Organization, 2015c). In some cases, it is acknowledged that community support and ownership of the response is needed, as clinical resources alone would not stop a disease outbreak (World Health Organization, 2015c). However, community-level leaders

are not featured as owning or leading response efforts. Instead, the literature depicts international responders and state institutions executing vertical community engagement strategies to identify and resolve supply and demand-side barriers. A vertical response is a top-down intervention that does not incorporate knowledge from local stakeholders in the decision making process. These are referred to as the ‘public transcripts’, using Scott (1992)’s concept of how knowledge communicated to the public is framed in a power-laden context, often ignoring voices from marginalized communities.

However, informants say that the governance of the EVD epidemic was managed with community-led engagement (self-organizing), and aid sometimes supported this, which challenges the public transcripts in the literature reviewed (Cenciarelli et al.; 2015; Dhillon and Kelly, 2015; Fallah et al., 2016; Fu, Robertson, and Burnham, 2015; Hagan et al., 2015; Laverack and Manoncourt, 2016; Lokuge et al., 2016; Sharma et al., 2014). Hence, these are ‘hidden transcripts’ as these are voices that have been marginalized in the debate (Scott, 1992). In Sierra Leone, in the areas that initially adopted the bylaws, EVD cases had already begun to resolve before the phase two scale up of aid resources (World Health Organization, 2014a).¹³⁴ In Liberia, traditional and community leaders conducted various engagement efforts in their communities. Therefore, aid resources were able to penetrate the community because of these leaders. They largely resolved the demand-side barriers, making aid more effective in some places (e.g. by increasing demand for health facilities). In some places with little or no aid support, institutional changes also helped prevented EVD (e.g. ban on secret society rituals and handshakes).

Donors and humanitarian agencies tend to govern the supply-side of the market. They can bring medical equipment, drugs, HRHs, or training. This is not to say that there were not challenges in the supply-side that slowed the response as discussed in chapter one, section 1.6 (Boseley, 2014; Gostin and Friedman, 2014; Kamradt-Scott, 2016). Other than demand-side barriers, there were also logistical problems that prevented these resources from penetrating the community such as government corruption, poor road networks, or travel bans preventing some resources from entering the countries (Bullard, 2018; DePinto, 2016). A brief discussion on the gains and drawbacks of this multi-institutional response is recapped in section II, part b below.

¹³⁴ This is using the timeline of that the thesis proposes, where phase two begins October 2014. See Introduction on page xxii.

II. Traditional Local Institutions Have Good Governance

As discussed in chapter two, Acemoglu, Reed, and Robinson (2014), Beekman, Bulte, and Nillesen (2013; 2014), Hanlon (2005), Jackson (2005; 2006; 2011), Mamdani (1996), Peters and Richards (1998), and Richards (2005) say that traditional leaders tend to be corrupt, and this corruption leads to underdevelopment in local communities. Additionally, there is the question of whether TLIs are still relevant to the modern state. Hanlon (2005), Jackson (2005; 2006), Peters and Richards (1998), and Richards (2005) argue that in West Africa, TLIs were the cause of the war, where young rebels held grievances against traditional leaders. These writers say if the chieftaincy is reinstated, it could hinder post-conflict recovery in the Mano River region.

On the other hand, arguments that support keeping the chieftaincy have relied on cultural and religious reasons to explain why TLIs will always be needed despite how the state develops (Adjei, Busia, and Bob-Milliar, 2017; Fanthorpe, 1998; Fanthorpe, 2001; Fanthorpe, 2006; Logan, 2013; Ubink, 2008). The thesis does not disagree with the premise of this argument; however, cultural and religious authority varies from state to state and within the state. For example, Nigeria did not always have traditional leaders come from the same ethnic background as the constituents (Iyanya, 2018). In addition, not all traditional leaders have religious authority (Richard, 2016). Nonetheless, rooting the legitimacy and authority of the chiefs in cultural and religious foundations is simply the beginning of understanding their authority and role in the community and not the entire picture.

The thesis holds that this binary debate is not helpful in today's circumstance, because the chieftaincy has withstood the test of time and external interference (colonialism, state institutions, and good governance reforms). This does not help us to understand how TLIs govern and their outcomes. Additionally, some key critics such as Richards, have evolved their research on TLIs where more recent work feature them as key institutions in local governance (Richards, 2016; Bulte, Richards, and Voors, 2018). Also, Mamdani (1996) has been referenced in much of this literature for referring to chiefs as despotic. However, this was regarding the manipulation of chieftaincies during the colonial era and how they were made more authoritarian. His broader thesis is that 'customary law' and 'ethnic identity' is rooted in nativism that did not exist before (Mamdani, 2001).

Therefore, a third perspective is introduced and this is the debate that the thesis contributes; this discusses evidence-based research on the outcomes of leadership and governance by traditional leaders (Acemoglu, Reed, and Robinson, 2014; Baker, 2007; Baldwin, 2015; Beekman, Bulte, and Nillesen, 2013; Beekman, Bulte, and Nillesen, 2014; Casey, Glennerster, and Miguel, 2012; Dia, 1996; Pande and Udry, 2005; Sesay, 2019; Tokpa and Yengbeh Jr., 2012; UNDEF, 2014; Unsworth, 2010).

Broadly speaking, this debate acknowledges the challenges of traditional leadership such as corruption and patrimonialism; however, when development projects or governance reforms engage with TLLs, researchers say that barriers to implementation decrease (Baldwin, 2015; Casey, Glennerster, and Miguel, 2012; UNDEF, 2014; Unsworth, 2010). Nonetheless, these leaders are also self-interested actors and this research is not to romanticize them (Baldwin, 2015). Traditional leaders have deep social and economic interests in development projects since they live in these communities too and are known by name by their constituents; thus, they will be held accountable by them. This notion contradicts a principle of good governance (World Bank, 2002), as there are ways to have accountability in a nondemocratic government.

A. Bylaws as a Choice of Governing

This leads us to another point to be made regarding the governance of traditional leaders during the 2014 Ebola epidemic, which points to a weakness in the good governance concept.

As proposed by the World Bank (2002), good governance relies on short-term interest as a rationale for cooperation. However, an analysis is needed to understand why there is long-term cooperation. Short-term election cycles can sometimes incentivize officials to create policies to promote oneself for the next campaign and not long-term policies to benefit the community (Baldwin, 2015). Therefore, coming into power by an electorate does not guarantee accountability or good governance.

However, social capital in the form of patrimonialism can create inequalities, as those who are connected would benefit more from the unequal redistribution of goods or services (Acemoglu, Reed, and Robinson, 2014). Building on this, we would expect that the chief, who started the bylaws in Kailahun, would have campaigned for more aid so that he could redistribute these resources via patron-client networks, which would have been a

popular choice and fulfill short-term interests for cooperation (Van der Windt and Voors, 2020). Instead, he gambled on his reputation to pass restrictive bylaws on people's intimate lives, such as banning handshakes. Thus, for those authors who believe that TLIs exhibited poor governance during the outbreak due to state capture or corruption, lack an explanation on how this happened and why passing the bylaws benefitted the chiefs in this way (Boland and McKay, 2018; Enria, 2017; Wilkinson et al., 2017).

This research shows that chiefs and secret society leaders across Kailahun, Kenema, and Bo districts agreed to pass the bylaws because of the fear and helplessness experienced in the midst of the crisis. Moreover, after witnessing health workers who once saved lives, now die in grotesque fashion from EVD; it may not have been considered rational to advocate for more clinical resources. Nonetheless, in the eastern and southern provinces of Sierra Leone, bylaws were passed before the state and international responders scaled-up aid, which did not give them the same opportunity to extract resources for personal gain.

The theoretical debate asks if traditional leaders can govern for the "good of the community" like elected leaders. However, there are two things wrong with this. First, it is naïve to assume that state leaders are not self-interested actors, they are and so are traditional leaders as explained in Baldwin (2015). However, as self-interested actors who live in the community, they too will benefit from social and development policies. Second, all evidence and research on corruption and political infight during the Ebola outbreak, has so far been on state institutions (DePinto, 2016; Ross, Welch, and Angelides, 2017; Sheplar, 2017). Although there is a dissenting opinion on the efficacy of bylaws and traditional authority (Boland and McKay, 2018; Enria, 2017; Wilkinson et al. 2017), these had not produced evidence of poor governance from the chiefs.

However, the criticisms that sometimes the chiefs were ineffective at enforcing the bylaws is merited, as we see that sometimes chiefs had to succumb to political pressure by constituents (Richards et al., 2015) or preferred a more democratic way of governing, but which led to higher EVD deaths (social costs) (Goguen and Bolton, 2017). The latter would be antithetical to our concept of high institutional quality.

Additionally, Enria (2017) mentions that the bylaws reopened a debate between the rights of the individual versus the rights of the group. In other words, in emergency management, how do we maintain the collective well-being of the group without infringing on the individual's rights for the sake of security? The thesis holds that this case study does

not fit into this debate, because the norms and laws of TLIs had always reflected communitarian values and not just during an emergency period as a short-term response. In chapter two, section 2.4.3, a brief discussion of customary laws and its socio-legal philosophies demonstrate that human rights are advocated through a collective voice and paternal responsibility (Frémont, 2009; Maimela, 2019; Mqeke, 1996).

B. TLIs and the State

There is a long and conflicting history between state and traditional institutions in West Africa (Harris, 2013; Mulbah, 2018; Sawyer, 2004; Tokpa and Yengbeh Jr., 2012). As mentioned in the introduction, during the colonial period, they were either ignored or their powers were consolidated to reflect European-style monarchies (Iyanya, 2018). Post-independence, state institutions created strong central executive offices, which impacted their relationship with TLIs. In Liberia, chiefs and clan leaders were merged into the state and became agents of the centralized government, enforcing the laws created in Monrovia (Nyei, 2014). Whereas in Sierra Leone, all forms of local government were abolished under the Stevens' regime (Jackson, 2006). Now in the post-conflict period, states are re-integrating TLIs into overall public administration (Chieftaincy Act, 2009; Local Government Act, 2015; Local Government Act of 2018, 2018; The Local Government Act, 2004). However, this is not without political implications as demonstrated by this case study.

As discussed in chapter five, a multitier institutional response governed this disease outbreak; and the relationship between state, traditional, and aid institutions helped or hindered each other's actions. In Sierra Leone, some of the bylaws helped aid institutions, as it created a demand for their resources and it gave health and humanitarian workers protection to enter and work safely in communities. Later, police and military resources, provided by the state, helped staff local checkpoints and enforce quarantine measures; therefore, improving the efficacy of traditional governance. However, a slow response of burial teams coordinated by state and aid institutions meant that the bylaw banning funerals was less effective. If a burial team did not arrive soon after a death, sometimes a funeral had to be conducted. Or as Ross, Welch, and Angelides (2017) found, corrupt practices by local politicians allowed some people to perform 'secret burials' instead of reporting the deaths to the local authorities. In Liberia, state and aid institutions were actively engaged, however, TLIs acted in silo (Hagan et al., 2015) and were later 'integrated,'

into the national response but superficially (Nyenswah et al., 2016). According to Nyenswah et al. (2016), they were only given cell phones to report new EVD cases or deaths in November 2014. Some key informants expressed that state and aid resources were not made available to assist them in self-organizing. However, Liberian health workers felt that aid interventions were positive. This would make sense as HRHs are part of the supply-side of the market and these were scaled-up by donors and humanitarians in phase two.

These drawbacks demonstrate that if social outcomes are affected by other institutions, then perhaps not all the market failures are resolved; hence, there could still be high costs. For instance, could identity politics, which was discussed in chapters one and two, hinder cooperation between traditional and state institutions?

This was answered in the findings chapter in the Sierra Leonean interviews. The party in power was the All Peoples' Congress (APC), which is historically dominated by the Temne and Limba ethnic groups from the northern province, and the southern and eastern provinces are predominantly Mende. There may have been some identity politics in the response. However, while much had been speculated in the past about ethno-regional tensions; the bylaws started in the Mende chiefdoms and the collaboration of both institutions transcended this.

C. Social Outcomes Are Important Too

The thesis holds that there should be a stronger reflection of social outcomes in the indicators of governance. These outcomes are best represented in qualitative research, which may make it challenging for policy makers because quantitative data is preferred so the results can be generalized. However, there is more research advocating for qualitative approaches in institutional analyses (Skarbek, 2020).

Social issues such as health have been made quantifiable, as discussed in chapter one on performance-based targets.¹³⁵ The Millennium Development Goals (MDGs) were global targets for each country and they received funding via the Poverty Reduction Strategy (PRS) to address social and economic barriers (Vandemoortele, 2008). However, aligning aid to three narrowly defined health issues in the MDGs created distortions in health planning in many low-income countries. Mostly Western-derived nongovernmental organizations

¹³⁵ See pages 7 through 11 on health interventions and HIV/AIDS as an example.

(NGOs) delivered these services to improve specific governance indicators as shown in the health statistics in chapter one, section 1.5.1 (World Health Organization, 2012b; World Health Organization, 2016b; World Health Organization, 2016c). However, broader health issues were not addressed in same way (Harman, 2015; Mustapha, 2006). This means that having good performance on an MDG target, such as maternal infant mortality (MMI), does not mean there is good performance on a nonMDG health problem, such as alcohol consumption or Diabetes. The current Sustainable Development Goals, which replaced the MDGs after it expired in 2015, are broader and include 47 health-related goals (Lim et al., 2016). However, time will tell how this initiative closes the gap where the MDGs have not.

Some donors and humanitarians used a community-level approach such as the formation of health committees, which was also mentioned in chapter one's discussion of Liberia and Sierra Leone's health systems (Bedford and Miller, 2017; McMahon et al., 2017). In some areas, a stakeholder group of community leaders, volunteers, and health workers governed specific health MDG challenges (such as MMI) and improved the indicators. In Sierra Leone, the traditional leaders passed bylaws to encourage health-seeking behaviors and increase demand of prenatal and antenatal services (McMahon et al., 2017). So, there is prior evidence of rulemaking to increase demand in health services, especially when aid institutions support local governance institutions.

Other development initiatives also leveraged traditional and community leaders to execute projects, such as the village development committees' projects discussed in chapter two, section 2.4.2 (Casey, Glennerster, and Miguel, 2012; Fearon, Humphreys, and Weinstein, 2009). From Casey, Glennerster, and Miguel (2012)'s experiences in Sierra Leone, committees that did not include a traditional leader often saw projects stall. This contradicted an initial objective to change decision making at the local level and avoid perceived authoritarian figures. However, Baldwin (2015), Bulte, Richards, and Voors (2018), and Pande and Udry (2005) say that these leaders have social capital to mobilize efforts where needed; and while social capital is sometimes used in the literature to describe influence and power (Acemoglu, Reed, and Robinson, 2014; Sawyer, 2005b), we sometimes do not explicitly say that this is a leadership trait. And simply put, that community-level authorities need to be engaged for these types of projects because of their leadership skills, in addition to the legitimacy and authority they hold.

Therefore, redefining institutional quality for social outcomes helps us think more deeply as to why we evaluate institutions for weak or strong governance. The traits needed to mobilize cooperation on a social challenge, where they may not be any immediate or short-term incentives are different. This is especially true in a public health emergency, where local challenges such as stigma, are different from other disasters (Arola, 2008). Consequently, communication, local knowledge, strategic planning, and liaison abilities are needed to tackle these challenges to contain a disease outbreak. Thus, this extends our vision of TLIs beyond the ‘cultural brokers or cultural mediators’ label to effective leadership for social outcomes.

Given the context of public health emergencies and development initiatives such as the health committees, it is not surprising to see traditional and community leaders governing on these taskforces. Future research in Institutional Economics should include qualitative data and methods when examining nonstate and nonurban-based institutions on social policy. TLIs in West Africa did more than end EVD, other health services were compromised, and many people died to due preventable nonEVD related conditions. The economy also stopped during this period. Resolving the social welfare crisis of the outbreak led to a return of economic activities in the short-term and reduced negative long-term impacts. This affects economic growth too. Thus, this brings us to our final contribution on policy and where these institutions fit in the future.

III. Looking Ahead

In public health, the question to ask is ‘when’ and not ‘if,’ because variations of acute and chronic health crises will always exist. So, policymakers and public administrators continuously seek to improve infrastructure and response mechanisms to contain a disease at the epicenter. This section focuses on the thesis’ policy contribution on how to take forward the lessons learned from studying the 2014 Ebola epidemic.

Advocates and scholars have argued that current development initiatives have not strengthened the health systems, but instead have funded Western-derived agencies to provide limited services to improve specific performance-based indicators as discussed in chapter one (Chorev, 2013; Harman, 2015; Johnston, Deane, and Rizzo, 2015; Kickbusch, 2005; Mathews, 2007; Mustapha, 2006; Parks, 2014; Petit et al., 2013; Sharples, 2015).

Therefore, global health policies have left Liberia and Sierra Leone in a vulnerable position to a disease outbreak (Kickbusch and Reddy, 2015; Rabkin and El-Sadr, 2015). In West Africa and other low-income countries, strengthening the health systems (e.g. universal health coverage and HRHs) may help to ensure preparedness for emergencies (Kickbusch and Reddy, 2015; O’Hare, 2015; Rabkin and El-Sadr, 2015; Vandi et al., 2017). Although it was not within the scope of the thesis to analyze these global health governance policies, the thesis does not disagree with those lessons. However, based on evidence from the field, the thesis holds a policy recommendation too.

As mentioned in chapter one, after the outbreak in Sierra Leone, President Koroma increased the number of paramount chiefs to deepen decentralization efforts (Concord Times, 2017). This was with the support of the World Bank, which proposes that the way forward is to align the work of TLIs with that of local councils. Specifically, it recommends more revenue-sharing and well-defined responsibilities to create collaboration instead of competition. These recommendations were based on the governance exhibited by TLIs during the outbreak (All Africa, 2017; AYV Media Empire, 2017; Cocorioko, 2017; Concord Times, 2017). Thus, state governments are engaging more with local governing institutions, and not banning or limiting them. This is the path forward. Specifically, the thesis recommends a bilateral knowledge exchange to create an infrastructure to respond in future outbreaks.

- A bilateral knowledge exchange is not training. It is engaging with key national and local stakeholders to create a response mechanism. Or in some cases, find out what infrastructure already exists. For example, Ross, Welch, and Angelides (2017) found that a disaster response unit already existed in Sierra Leone’s government with a protocol that included TLIs and the Ministry of Health and Sanitation. However, they were not engaged in the beginning, despite being well-resourced at the district levels. This could have changed the pace of the outbreak, if community and national leaders knew what infrastructure already existed and enacted on it.
- This should be a community-led engagement, with domestic and aid resources assisting, rather than expecting communities to support a vertical intervention. For example, Hewlett and Amola (2003)’s work of the Ebola outbreak in Uganda show that survivors of *gemo*, would be responsible for preparing corpses for funerals and caring for the sick. This ensured that EVD corpses were buried quickly and in respect to local customs, as opposed to relying on overstretch resources (i.e. ambulances and burial teams). In Liberia, aid organizations did not penetrate most rural areas. So, one village devised an irrigation system to promote handwashing in public spaces.

Hence, local communities can devise a strategy on safer burial methods as well as caring methods; and have resources to support their strategies.

- Community leaders and peers, who are leading emergency response efforts, should be identified internally and not by national governments or international responders. Ideally, this would prevent having resented actors in charge during an emergency, as we witnessed in some areas of Guinea during the outbreak (Wilkinson et al., 2017). Thus, traditional leaders passing bylaws universally may not be helpful, but findings from Liberia show that nontraditional leaders (i.e. community leaders) did change local norms to encourage healthier behaviors, even without formal rulemaking powers.
- International humanitarian responders should avoid over-standardizing and medicalizing response efforts. As discussed in chapter five section 5.2.3, there is a pattern in the Western discourse of discrediting locally-derived solutions or ignoring them if they do not use a biomedical approach. Relying on pharma-medical solutions (as in the example with oral rehydration therapy) can harm local communities rather than help. This is especially true in a low-resource context where medical equipment may not be in abundance or exist at all. Therefore, interventions should focus on how to assist community-led strategies with behavior changes or what supplies can assist them to execute their strategies. This will involve working with community-level leaders (identified internally), rather than those 'known' to NGOs and donors as critiqued by Nyenswah, Engineer, and Peters (2016). They demonstrate that part of the challenges in Liberia was aid institutions not relinquishing control of resources to local stakeholders, which support the informants' interviews.

Ignoring TLIs and community institutions can lead to poor outcomes in development projects (Adjei, Busia, and Bob-Milliar, 2017; Baldwin, 2015; Casey, Glennerster, and Miguel, 2012) or without trusted leaders in an emergency as demonstrated again by the recent 2018 EVD outbreak in the Democratic Republic of Congo (Beaumont, 2019; Ebola Gbalo Research Group, 2019; Vinck et al., 2019; World Health Organization, 2019b). The public transcripts depict aid organizations as resolving supply and demand-side barriers, and not community-led strategies or how local leaders are incorporated. For instance, it still argues the stereotype that providing biomedical knowledge will increase the demand for aid resources (Cohen, 2018; Ilunga Kalenga et al., 2019; Médecins Sans Frontières 2018a; Médecins Sans Frontières, 2018b; Médecins Sans Frontières, 2019; Moran, 2018; Nkengasong and Onyebujoh, 2018; World Health Organization, 2018e). However, we see the same market inefficiencies of information failures such as mistrust and stigma. This is because the

problem is not lack of biomedical knowledge, but rather lack of trusted local leaders to disseminate information and engage with the community (Vinck et al., 2019).

IV. Limitations to Build On

There were some limitations to the research project discussed in chapter three, section 3.9. However, this section highlights the limitations that have brought up new questions worthy of future research.

This thesis did not explore the full impact of civil conflict on TLIs in the case study countries. However, it referred to studies on subsequent institutional changes in how communities perceive the state and participate in local political processes in the post-conflict era (Baker, 2007; Baldwin and Mvukiyehe, 2015; Bellows and Miguel, 2009; Sawyer, 2008; Voors and Bulte, 2014). The fieldwork for this thesis did not obtain primary data on this. Further research is needed, particularly on how these institutions evolved during the post-conflict period. Additionally, more research is needed on how the 2014 Ebola epidemic led to institutional changes of traditional authorities and organizations (secret societies), as this thesis indicated that an external shock may have created some permanent changes (e.g. the blood rituals and local governance on health).

The member checker from Sierra Leone discussed the 2014 census that was supposed to take place (Appendix C). However, it was canceled due to EVD cases in the eastern region of the country. It was suggested that this was a political controversy that contributed to why some people denied the existence of the disease in the country. Sierra Leone has a history of census manipulation for political purposes (Bockarie, 2015). Research may also add critical analyses of how denials and stigma have been interpreted in the literature of the outbreak on top of what was discussed in the thesis. Currently, media sources attribute local fears and perceptions to a lack of biomedical knowledge on illness or an attempt at genocide (Dixon, 2014; Mark, 2014).

The phenomenon of bottom-up rulemaking was only observed in Sierra Leone in this case study, and it was not within the scope of this Ph.D. project to demonstrate if the findings apply to other contexts (Noble and Smith, 2015; Thomas and Magilvy, 2011). There is an indication that bylaws and rulemaking occurred in other countries affected by the outbreak (Elemuwa et al., 2015; Miller et al., 2018). Moreover, research on the involvement

of community-level leaders in the 2014 Ebola outbreak in Guinea and Nigeria or the recent 2018 Ebola outbreak in the Democratic Republic of Congo would be worthy of future exploration. This latter outbreak is of particular interest, because so far, the public transcript mimics the same themes from the 2014 EVD outbreak, regarding international responders' role. The challenges of trust and legitimacy in the communities are apparent even though this country has had many Ebola outbreaks in the past, and the world had witnessed the West African outbreak, which provided valuable lessons about the demand-side barriers (Chandler et al., 2015; Parker et al., 2019; Wilkinson et al., 2017). It is important now, more than ever, to apply these lessons in future emergency management.

APPENDIX A

Interview Questionnaires

Pre-pilot questionnaire for health workers.

1. Tell me what it is like to work as a (doctor/nurse/midwife) at your clinic/hospital.

Probing:

How many patients line up for service?

How many patients would you see on average (per day or per week)?

What services are provided here?

Do patients pay a fee for service?

2. Since the civil war ended, how have health services changed until 2013?

Probing:

Have more or less services come to this area?

What kind of services were introduced or reduced?

How has the volume of patients changed?

3a. What changes have there been in patients coming in?

Probing:

Have you had to turn away more or less patients?

A change in demographics of people coming in for care?

What are the trending risk factors (e.g. a rise in non-communicable diseases, a decline in services for a specific issue)?

3b. How have health human resources (HRHs) changed since the end of the civil war?

Probing:

How have universities or training centers functioned to train new health workers?

How has the level of staff changed in this area?

How has the level of HHR changed the health services delivered in this area?

How are staff integrated from school into the local setting?

4. How have resources to your clinic/hospital changed?

Probing:

Does the clinic get reimbursed for prescriptions? Has the reimbursement scheme changed?

Are medical supplies arriving to the clinic/hospital on a consistent basis?

Are supplies enough to cope with the flow of patients?

Do funds come consistently to pay for other expenses like utilities or maintenance?

Does funding include money for support staff?

5. How were your clinic and area affected by the Ebola epidemic?

Probing:

How did the volume of patients change?

How were health workers affected?

Were resources to keep the clinic functioning still consistent or had changed?

Did any external assistance arrive to the area (NGOs)?

6. What do you think happened during the Ebola outbreak that helped or hurt your ability to provide care?

Probing:

Extra or inconsistent resources?

Stigma?

Management practices? (e.g. training on personal protection equipment or infection control).

7. What policies were enacted during the Ebola outbreak that affected health workers or the health industry during the epidemic? Did they help or hurt, why or why not?

Probing:

New isolation or containment measures?

Health screenings at borders?

8. How were voices/perspectives of healthcare workers integrated when these decisions were made during the outbreak?

Probing:

Any meetings between health workers and local officials or stakeholders?

Any community-based meetings arranged, like town halls?

9. How do health workers currently advocate or have a voice in the governance of healthcare?

Probing:

At any time not just during an outbreak.

Are there organized unions?

Do workers have discretion in implementing services and programs?

Are there demonstrations?

10. How did health workers organize during the outbreak?

11. What changes in the law will affect how you or your colleagues provide care and services?

Probing:

What upcoming or pending changes may affect your services?

Changes in user fees?

Will the law affect volume of staff?

12. Thinking about the patients that come here, what group of people are not being reached for healthcare?

Probing:

Why do you think they are not coming in for services?

13. What can be changed to provide more efficient services and care to patients?

14. How can health workers have more of a voice in the processes that affect health governance?

15a. How do you see healthcare in this community evolving in the medium-term (5-7 years)?

Probing:

Population changes?

Increase or decrease in services?

Change in external providers of care?

15b. How about in the country, generally?

Probing:

Population changes in those who can access health services

Resilience to manage infectious disease outbreak
Managing noninfectious diseases (e.g. heart disease, cancer, diabetes etc...)

Post-pilot questionnaire for health workers

1. What are the main challenges at your clinic/hospital?

Probing:

How many patients line up for service?
How many patients would you see on average?
What services are provided here?
Do patients pay a fee for service?

2. During what period have health services been better or worse?

Probing:

Have more or less services come to this area?
What kind of services were introduced or reduced?
How has the volume of patients changed?

3a. What changes have there been in patients coming in?

Probing:

Have you had to turn away more or less patients?
A change in demographics of people coming in for care?
What are the trending risk factors (e.g. a rise in noncommunicable diseases, decline in services for a specific issue)?

3b. How have health human resources (HRHs) changed since the end of the civil war?

Probing:

How have universities or training centers functioned to train new health workers?
How has the level of staff changed in this area?
How has the level of HHR changed the health services delivered in this area?
How are staff integrated from school into the local setting?

4. How do you use the resources, despite the constraints?

Probing:

Does the clinic get reimbursed for prescriptions? Has the reimbursement scheme changed?
Are medical supplies arriving to the clinic/hospital on a consistent basis?
Are supplies enough to cope with the flow of patients?
Do funds come consistently to pay for other expenses like utilities or maintenance?
Does funding include money for support staff?

5. How did you see the effects of the Ebola outbreak?

Probing:

How did volume of patients change?
How were survivors treated in the community?
How were health workers affected?
Were resources to keep the clinic functioning still consistent or had changed?
Did any external assistance arrive to the area (NGOs)?

6. What do you think happened during the Ebola outbreak that affected (help or hurt) your ability to provide care?

Probing:

Extra or inconsistent resources?

Stigma?

Management practices? (e.g. training on PPE or infection control. Getting people educated about the disease and behavioral changes)*

7. What are the strengths and weaknesses of policies/procedures enacted during the Ebola outbreak?

What worked and what didn't?

Probing:

New isolation or containment measures?

Health screenings at borders?

Involvement of local chiefs or councils?

8. How were voices/perspectives of healthcare workers integrated when these decisions were made during the outbreak?

Probing:

Any meetings between health workers and local officials or stakeholders?

Any community-based meetings arranged, like town halls?

9. What role do health workers have in the governance of healthcare?

Probing:

At any time not just during an outbreak.

Are there organized unions?

Do workers have discretion in implementing services and programs?

Are there demonstrations?

10. What are the incentives to keep health providers working?

11. What changes in the law will affect how you or your colleagues provide care and services?

Probing:

What upcoming or pending changes may affect your services?

Changes in user fees?

Will the law affect volume of staff?

12. What kind of patients are not coming in for healthcare services?

Probing:

Why do you think they are not coming in for services?

13. What can be changed to provide more efficient services and care to patients?

14. How can health workers have more influence in the processes that affect health governance?

15a. How do you see healthcare in this community evolving in the medium-term (5-7 years)?

Probing:

Population changes?

Increase or decrease in services?

Change in external providers of care?

15b. How about in the country, generally?

Probing:

Population changes in those who can access health services

Resilience to manage infectious disease outbreak

Managing noninfectious diseases (e.g. heart disease, cancer, diabetes etc...)

Questionnaire for community stakeholders

1. Since the end of the civil war, how did the health sector function?

Before transition before new government?

Before Ebola?

During Ebola?

And after the Ebola outbreak?

2. The response to Ebola in the beginning took longer than expected, why do you think that happened?

Probing:

Lack of Knowledge?

Organizing Resources?

Politicizing Issues?

3. What are the strength and weaknesses of the response during the outbreak? What worked and what didn't?

Probing:

A. How does that compare to other disease outbreaks? What happened differently?

HIV

Cholera

Lassa Fever

4. What are the main challenges in the healthcare system?

Before the Ebola epidemic

During the Ebola epidemic

And going forward after Ebola

5. What are the incentives that keep health providers working?

6. What was the relationship between the central government and local authorities in fighting Ebola? (e.g. local councils and chiefs)

A. How does that compare to prior health emergencies or campaigns?

7. How do you see the role of stakeholders going forward? (chiefs, councils, elders...)

8. How does the community view the government/private health services?

A. Does this change with external/NGO services?

9. How do survivors or family members integrate back into society?

A. How does this compare with survivors of other diseases? (e.g. HIV)

APPENDIX B

This section contains blank copies of the participants' information sheet and the consent form used in West Africa. The information sheet gives an overview of the research project and contact details for the researcher and supervisor at the University of Westminster. There were two mobile numbers given, a permanent British mobile number, which is redacted for the purposes of this thesis and a temporary local one was written in the line provided. The consent forms were signed by the informants and returned to the researcher.

Participants' Information Sheet

The Healthcare of West Africa and The Role of 21st Century Global Governance Information Sheet

Principal Investigator: Sabine Franklin
Email: w1577261@my.westminster.ac.uk

Phone number(s): XXXXX-XXXX31

Who is doing the research?

My name is Sabine Franklin and I am a post-graduate student at the University of Westminster in London, United Kingdom. I am conducting this research for my Ph.D. project, and I have an interest in studying health policies, economic development, and health disparities. I am not affiliated with any other organization or collaborators on this project. This project is not funded by any other corporation or external organization.

Purpose

You are being asked to participate in a research study on governance and access of healthcare systems in Liberia and Sierra Leone. The purpose of this study is to understand the level of services of the healthcare system, accessibility, and response and effectiveness during the 2014 Ebola epidemic. You were selected as a possible participant because you are a worker or volunteer in the formal healthcare system.

What you should know about this research study:

- I am providing you with this participant information and consent form so that you may read about the purpose, risks, and benefits of the research study in which you are about to participate.
- Routine care refers to the best-known treatment, which is provided with the aim of helping the individual patient. The main aim of research studies is to gain knowledge that may help you and/or future patients.
- I cannot promise that you will gain benefit from this research.
- It is your right to agree or to refuse to take part in the research, and you may change your mind later.
- Your decision will not affect your routine health care or social services.
- Please review this consent form carefully and ask any questions or raise your concerns regarding the research before you take a final decision to participate or not in the study.
- Your participation in the research is totally voluntary.

Procedures and Duration

If you decide to participate in the study, you will undergo a one-on-one interview with the principal investigator. It is expected that you will only be interviewed once.

Risks and Discomfort

The nature of the project is to talk about health care services and the system of healthcare. It is possible that you may bring up memories or experiences around death, stigma, and /or trauma which may cause distress. The research will be conducted through one-on-one interviews, and there will no physical or biological tests conducted.

THIS INFORMATION SHEET IS YOURS TO KEEP.

If you have any questions concerning this study or consent form beyond those that have been answered by the investigator, including questions about the research, your rights as a research participant, or the implications of research-related injuries, or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact: Dr. Hannah Cross, University of Westminster, London UK. +44 020 7911 5000 ext. 68909 or H.Cross@westminster.ac.uk

Informed Consent Form

The Healthcare of West Africa and The Role of 21st Century Global Governance Consent Form

CONSENT FORM

Confidentiality

Any information that is obtained in connection with this study that can identify you will remain confidential and will be disclosed only with your permission.

Voluntary participation

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the University of Westminster, its personnel, and associated hospitals and organizations. If you decide to participate in the study, you are free to withdraw your consent from participating in the study, and to discontinue participation at any time without penalty to yourself.

Benefits and/or Compensation

I cannot promise or guarantee that you will receive any benefits from this study. The risk of physical harm is very low compared to the advantageous benefits of gaining knowledge of the country's individual healthcare system and how health workers negotiate power at a street-level bureaucracy. Understanding power relations and health services delivery at the micro level contributes to the field's scope of knowledge on policy and the impact of external influences. The risk of psychological harm is also low, as the questions and topic do not focus on personal loss.

Offer to Answer Questions

Before you sign this form, please ask any questions regarding any aspect of this study that is unclear to you. You may, within reason, take as much time as you need to reconsider your participation in the study.

Authorization

You are making a decision as to whether or not you are willing to participate in this study. Your written consent indicates that you have read and understood the information provided above, have had all your questions answered in relation to the study, and have decided to participate in it of your own free will.

Audio recording

Your informed consent and interview will be audio recorded on an encrypted digital recording device. This device is password protected so only the principal investigator can access the files. Files will be uploaded and stored on an encrypted operating cloud system. The data (interviews) will be used for this research and subsequent research articles on health and development by the principal investigator. There are no other collaborators or entities that will have access to this data.

Name: _____

Signature: _____

Date: _____

APPENDIX C

This section contains evaluative feedback from gatekeepers in Liberia and Sierra Leone. Each person was sent a copy of the findings, of their respective countries, from chapter four and was asked to give feedback on how the narratives and experiences were interpreted and portrayed. This transcript represents their verbatim responses, with very minimal editing for punctuation; thus, the transcript was left in its original dialect to minimize bias from the researcher.

Member Checking from Liberia

Wednesday November 14, 2018

Yes, I agree with what you say. These were the realities, the message, first of all, the manner and form the message came from the minister of health and social welfare [MHSW]; his first message was intimidating. If you were to access the minister's message in the first outbreak, the headline was, "No sex". That was his first message. That was the first message without doing any investigation or finding out, what, any issues were; his first message was, "No sex". So, it led people to panic and people were wondering, 'Who is this minister of health?' When there is an epidemic and his first message to the people is, "No sex?" They did not do any research and meanwhile the situation had already occurred in Guinea. So, there was no research on how the people in those countries helped in that situation. It created a panic. It was later, when WHO came in and tried to pass some guidance. And, as the health workers said, many facilities did not have the PPE and that was what led to the death of many workers. Those gloves and different stuff like that, were never, ever available. Also, there were no ambulances from the rural health facilities to the ETUs. The few that were available, when you call them, they were overwhelmed [with] taking all the patients. There were 2 or 3 ambulances in Montserrado County and taking calls from all other the country.

As a person [my experience], in terms of talking about local community engagement, the WHO brought a lady from Uganda, and fortunately she was a Catholic and she started attending mass at the same church as me. She died later, but 2 or 3 times I drove her to

service, but I found out she brought PPE for the community dwellers, but the people were not trained in using them. They did not know how to wear the gloves or if someone is sick, how to administer first aid. So, I contacted her through my pastor and we got involved. After every service at the church, we were allowed 30 minutes at the altar to demonstrate how to use the PPE and we recruited some young people from the parish and they were also taught how and distributed the PPE. So, people started using PPE effectively.

Also, I was living behind one of the ETUs; what I also saw, was so traumatic. The community engagement of local leaders, like the community chairperson and leader in each zones; so, I put myself in a zone. So, every morning in 2014, I had to drive through that zone, I had to encounter Ebola patients. Really, one success story going forward for any future outbreak was that the community engagement was very good. They did not wait for donor support and they took the issue into their own hands. We have the Muslims and Christians, and Muslims have a belief [ritual] that they undertook [prepare] the dead bodies, but because of the Ebola situation, the Muslims abandoned their traditional practices. But they were aware and brought on board the Imams and [Muslim] leaders to sensitize and educate their community. The fact that their own Imams and own people were used to carry out the message of sensitization played a major role. These messages of Ebola were translated into their own vernacular, so forget English and leaflets and billboards and those kinds of things. The Imams used their own mosques to do health education and pastors used their own churches to pass on the message.

Yes, we have health workers, and they were dying, and people lost confidence in the health workers. It is like, "This person was supposed to treat me, if they are dying then what more should I listen to them?" So, they turned to the community leaders, and even the issue of visitation was curtailed, as every person kept to their own household.

A typical example was like my own experience, where I knew this Ugandan lady at my church who is a health worker, so I engaged her. We did messaging after church services and then I started entering the ETUs. The recruitment of community health workers, normally, they go through the health systems (before Ebola, there were GCHVs), but they went through the community chairperson instead, during the Ebola. The quarantine was a natural behavior change, and every household now had a bucket. Before the Ebola crisis, people were not doing hygiene [handwashing], so with the outbreak of Ebola, every household had chlorine water placed in front of the house. So, every homeowner would

wash their hands before entering and after leaving the house. The government closed schools for a time (quarantine) and people had to stay at home too.

The MHSW first message of 'no sex' or public action came after 3 or 4 months, maybe August. When the disease entered Monrovia is when they got serious and that's one of the reasons that it spread. I saw the community people taking things into their own hands in August 2014.

All the donor support, like ambulances, the government today, cannot account for them; where those supplies are. So, if there is an outbreak today, there wouldn't be any ambulances.

One of things in the rural areas, we saw that NGOs couldn't reach them to distribute buckets; so they were creative to carve a "pipe" out of the bamboo reed, fill it with water, and pierce it with a nail and they can remove it and water spills out, so you can wash your hands. Things like that people had to do.

Member Checking from Sierra Leone

Sunday, December 9, 2018

In general, the health conditions in this country that you described before, during, and after the war, as well as during and after the Ebola, is correct. And during Ebola there was a stigmatization on health workers. You were right about the misinformation of the symptoms. Initially, it was said there was supposed to be hemorrhaging from everywhere, so health workers were looking for those signs, but if they don't see it, then they don't think you have Ebola. The government said that EVD started in southeast in Kailahun District which is an SLPP stronghold and it was near the census organizing. So, people thought that because we are about to start counting and they [government] say we have Ebola; they want to stop the census and reduce the numbers. You did not mention that in the analysis.

In 2014, the Sierra Leone government was about to conduct census and during the pre-sessions we heard about Ebola and the census leads up to 2017, which was meant for the national elections. So, people thought that since we are to organize the census and start voting soon, this was to stop us from voting. "This is lie, so they don't have to count us and come to Kailahun [and] deny us our vote." These were community people, and the SLPP said the government should explain why there is Ebola in Kailahun. They started politicizing it. In

terms of stigmatizing, you are right that people started sending health workers out of their homes. So, because there is no difference in signs between Typhoid and Malaria, people who were sick with that [nonEbola cases] went to the hospital and never came home. They were all treated like Ebola patients.

There were a lot of misconceptions of Ebola and there were no clear definitions of symptoms. You were right about when they said there was no medicine for Ebola; so, people thought what was the point? So, let our loved ones die in dignity as opposed to taking them to the hospital and letting them die there and we never see the corpse. A responsible government should have embarked on research. The government heard about Ebola in Guinea and they should have taken precautions to go into the field and do research and sensitization, but they never did that. Just like they knew there was war in Liberia but didn't take precautions to prevent that before it came to Sierra Leone. So, Ebola came here without any prior knowledge and caught us with our pants down. The minister of health was not a medical practitioner. What brought nationwide consciousness was when Dr. Khan died of the disease; the entire country panicked. Everybody knew it was not politics, it was reality. So, everyone became very conscious and afraid of Ebola. No one took Ebola seriously, even educated people did not believe the government, not until Dr. Khan's death.

You are right about the bylaws, also it is not *okada* drivers it is *okada* riders, and they were also fined if they carried people. In my case, when I went to the Kenema District in the Tongo chiefdom, they took me to the police station to give a statement, then to the chief to make a statement, and the guy that lodged me, also had to give a statement. Then, even when I went to my mom, my place of birth, my home, (Kenema town) she took me to the area chief. She didn't want to be fined, so we had to go. So, they asked me where in Freetown I came from, and I was in Kissi, so there were no cases of Ebola in that part of Freetown. The bylaws were very successful to a large extent, in fact we expect the bylaws more. Because we are in the city here [Freetown], we do not take the laws very seriously, we don't pay attention to local authorities, but because the towns are very small, so they took it seriously.

In Freetown, when U.K. DFID came and sent personnel to help, China and Cuba also sent people and started curing people; that worked in Freetown. They brought powerful test machines that could do all these tests, instead of everyone going to Kenema for testing and having to wait for their results. So, people realize that the message that, "Ebola is

incurable” was not true; we started hearing about survivors. As well as the handwashing and limiting contact with other people worked in Freetown. But the testing machines were another part.

I did not see anything that was not accurate, most of the things you wrote are what people said. You analyzed their accounts. The most important thing to mention about Ebola, is when government wanted to stop census and a lot of people denied existence of the disease and politicized it that way. The government was negligent to act: research, information, and messaging. It was more of a guess work.

There is no structured information system. The minister will say what she wants to say, the health workers will say what they want to say, and the spokesperson for the government will say what they want to say. So, sometimes there was no coherence in the information.

So, I read all the things you said about health workers and volunteers, there were complaints of health workers extorting money from patients before and during the Ebola. The volunteers were not paid, so they had to look for other means to get money. So, there were complaints from patients that government says, “There is free health care, but the health workers ask us for money.” So, people thought it was being done by volunteers, so that is one reason why volunteers were let go. The government also knew that they could not keep them on for long without paying them. That it wouldn’t be fair. So, they decided not to recruit the volunteers and let them go and may recruit them later. They knew the volunteers needed an incentive, but there was no provision for that.

Before the formation of the burial teams, people were burying their loved ones. So, when they said to report the burials, the teams were not responsive as they should be. One chiefdom or district could have one ambulance and maybe there is no gas for that ambulance.

The central government relied heavily on paramount chiefdoms, [as] there is no way Freetown authorities will go to Kailahun. The paramount chiefs relied on the section chiefs, then the section chief relied on town chiefs.

Up until now, we respect the military. So, when there were these laws, especially in big towns like Makeni, Pujehun, or Kailahun, they bring the military for enforcement. To enforce quarantine, you could not even go to your neighbor’s house; both the military and police patrolled to ensure people were in their homes. The government also distributed

soaps and other things and hired people to do this. They would come to your house and show you how to wash your hands and keep thing sanitized.

In the chiefdoms, there are no local police, so they must call the state police if someone is breaking the law. They would bring two officers (military or police) and bring rations and supplies while a house was quarantined for 21 days. They had a program that was responsible for feeding quarantined houses, since they were not expected to go to the market or leave their homes for any reason.

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