



Structural violence: Understanding mother & child health and Ebola in Sierra Leone

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“What on earth am I doing here?” Hanna Schneider took a sip from her bottle of soda while trying to fight off the mosquitoes and enjoy the cool evening breeze that blew across the veranda of the guesthouse.

As she relaxed after yet another hot, humid and exhausting day, she found it difficult to absorb all the things that had happened to her during the first week of her stay in Sierra Leone. Her mind was filled with many questions that she hoped to discuss with her colleague, Charles Koroma. While waiting for Charles, Hanna took a deep breath and tried to structure her thoughts and impressions from her first week. The first thing that came to mind was a situation from that morning.

Hanna Schneider

As a German obstetrician-gynaecologist in her mid-thirties, Hannah had already spent some time working in Africa, initially during her clinical internship in the Bugando Medical Centre in Tanzania. Subsequently, she increased her experience of working for international organisations through several short-term assignments in rural hospitals in Bukavu in the Democratic Republic of Congo (DRC), Gaoua in Burkina Faso and Kailahun in Sierra Leone.

For a Master’s degree in International Health within the TropEd network, she had spent five years following courses at several European institutions. Her studies had focused on clinical tropical medicine and reproductive health – her main areas of interest. She had not taken any courses in medical anthropology.

In the summer of 2014 Hanna was sent to Kailahun, where she had worked previously. Her assignment was to support the hospital's health services during the turmoil of the Ebola outbreak, which by then had reached its peak. This was her first long-term contract.

Charles Koroma

Dr Charles was one of the few trained clinical officers at the small hospital, which he ran together with a team of dedicated nurses. Raised in Sierra Leone during the years of the civil war (1991-2002), he often referred to himself as “lucky” because he was one of very few in his generation with a good education. He had studied at the COMAHS (College of Medicine and Allied Health Sciences) in the country's capital, Freetown. After his graduation, he received a scholarship and travelled to the UK to specialise in internal medicine. Hanna had great respect for his decision to then head straight back to Sierra Leone. He had even chosen to work in this remote rural town to help the local people, rather than accept a job at a large international hospital in Freetown.

Earlier that day

“What is going on?” Hanna asked the nurse who was with her doing rounds in the maternity ward. As they were looking at the temperature chart of one of her patients, the busy yet peaceful atmosphere had been shattered by the sudden screams of a woman in the room next door. Not waiting for the nurse to reply, Hanna rushed into the next room and found a nurse and a nurse-aid trying to comfort a weeping patient.

The nurse explained that the woman had been admitted during the night after having been in labour for over 48 hours. She came from a village about 50 kilometres away where she had previously given birth to three other children. These had been born with the help of the women in her village, the traditional birth attendants. Two of her children, now aged five and two, were still alive, but the middle one had died a year ago.

“Okay, but what’s the problem right now?” asked Hanna.

The nurse described how the woman had been almost unconscious when members of her family had arrived with her. Fetal heart sounds were very weak and finally, an emergency Caesarean section had been carried out because the baby was stuck in the womb in a difficult position. Luckily, they had then been able to stabilise the mother, although at one point they were afraid she would die. This morning her condition was much better and stable, due to the iv-fluids, blood transfusion and medicine she had been given.

“Sadly, though,” added the nurse, “when we delivered the baby, she was blue in colour. We tried to stimulate her, but she never began to breathe”.

Hanna knew that the resuscitation of newborn babies was one of the biggest problems not only in this hospital, but country-wide. Very little training was given to nurses on resuscitation techniques. Consequently, very few had any knowledge of what to do in these cases. There was also a lack of necessary equipment.

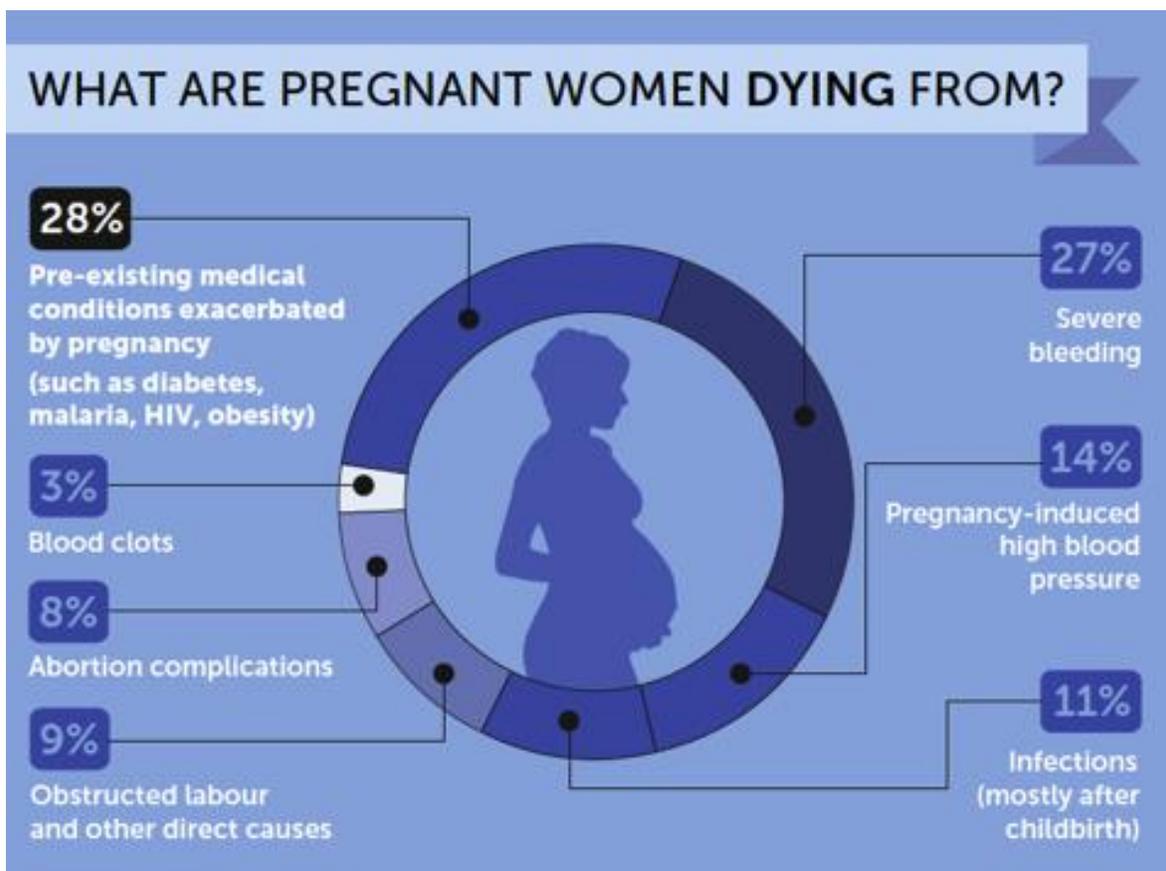
“We didn’t want to tell the mother what had happened right away, so we let her rest,” continued the nurse. “She learned only a moment ago that the baby had died. It appeared to be an otherwise healthy baby girl. If it hadn’t been for the obstructed labour, the baby would probably have lived.”

Hanna remembered what she had read about maternity care and child mortality rates in Sierra Leone. Frowning in concentration, she tried to dig out some facts from her memory.

Maternal mortality

Sierra Leone has one of the highest maternal mortality ratios in the world, with 890 maternal deaths per 100,000 live births, or a lifetime risk of maternal death at 1 in 23. The average for Africa is 510 and the world average is 210 maternal deaths per 100,000 live births. In a 2009 report, Amnesty International had claimed that the high maternal mortality was increasingly being regarded as a human rights violation, as the majority of the deaths are preventable.

A 2013 Demographic and Health survey further revealed that only 27% of new mothers reported having given birth in a clinic. The majority of women still give birth at home, unattended by skilled health workers. WHO AFRO claimed that although it was recommended that (given the possibility of labour-related complications) the proportion of Caesarean sections carried out should be between 5% and 15% of all deliveries, in Sierra Leone a Caesarean section was performed in only one to two percent of deliveries (Exhibit 2).



Under-five mortality

According to WHO AFRO data, Sierra Leone also has one of the highest under-five mortality rates in the world: 180 out of 1000 children die before their 5th birthday, compared with 90 in the WHO African region and 12 in the WHO European region. Remarkably, urban-rural differences are very small, meaning that in both rural and urban areas, under-five mortality rates are equally high.

WHAT IS NEEDED TO SAVE MORE LIVES?



Quality care before,
during & after
childbirth



Safe
blood
supplies



Essential medicines
such as antibiotics
and oxytocin



Contraception
& safe abortion
services



Every death is counted & its cause recorded



World Health
Organization

Child mortality is frequently due to infectious diseases such as malaria, pneumonia, diarrhoeal diseases and meningitis. The underlying cause for up to 45% of child deaths is acute and chronic malnutrition. In 2010, about 18% of all children living in Sierra Leone were found to be malnourished – a decrease of four percent since 2008. This was despite the fact that Sierra Leone is a fertile country, suffering none of the droughts and famines that affect other African countries (Exhibit 2).

Neonatal Mortality

Neonatal mortality counts as part of under-five mortality, but because the likelihood of dying during the first 28 days of life (called neonatal mortality) is substantially higher than in the subsequent childhood, it is regarded as a classification of its own within the under-five category. However, the statistics for neonatal mortality are known to be inaccurate, due to misclassification and under-reporting. Official numbers for neonatal deaths in Sierra Leone were 50 per 1,000 live births whereas globally, neonatal deaths constituted between 30 and 40% of under-five mortality, according to a WHO Report on Child Mortality causes from 2013. This infers that the real rate should be 60-70 per 1,000 live births in Sierra Leone, suggesting that there is substantial under-reporting.

Neonatal mortality is closely linked to maternal mortality. When a mother dies from giving birth, the likelihood of the newborn child surviving is only 10%. For the small percentage of newborns who survive, the likelihood of them reaching their fifth birthday is still a mere 50%. While the past years have seen much progress regarding child mortality as a whole, little progress has been made with regard to neonatal mortality (Exhibit 2).



Back in the room

Having rapidly reviewed these facts in her mind, Hanna turned to the situation at hand and asked the nurse why the mother had not been able to get to the hospital earlier.

The nurse sighed. “Do you know where she lives?” she asked Hanna. “From her village she had to walk for half an hour on foot to another village in order to get access to the mud road leading to the nearest town. The Primary Health Unit (PHU) in the village was not staffed – the nurse was attending a funeral. Luckily there had not been a lot of rain in the last few days as after heavy rains, no car can drive on the mud road. When the family tried to get transport into town, there was no gasoline available for the only vehicle. A family member living in the town tried to organise transport,



but it took him several hours and many phone calls to get the woman to the government hospital. She arrived there yesterday after spending two days in labour”.

Hanna interrupted the nurse. “So she was already in the government hospital yesterday? That hospital is much bigger than this one. How come they didn’t help her?” At that moment the mother stopped sobbing and haltingly tried to explain what had happened: “The nurses shouted at me,” she said. “They told me nothing about my condition and just asked me for 20,000 Leones [USD 5] for medicines. I had no money so they told me to go away.”

Wanting to comfort the young mother, Hanna took her hand. “I’m so sorry, Mama,” she said, trying not to show her anger at a system that could let something like this happen. Hanna wanted to continue her conversation with the mother, but just then the nurse she had originally worked with rushed in. She cried at Hanna to come back quickly as one of the patients in the other room had become feverish. Hanna promised the bereaved mother that she would come back to see her later, and then dashed off to deal with yet another emergency...

After work

As Hanna sat on the veranda, it occurred to her that it was only now that she finally had the time to think about the woman again. It was already getting dark and she realised she’d forgotten to eat lunch, which suddenly made her feel very hungry. Instead of eating, though, Hanna switched on her head-torch and looked through the charts again. She always did this as an end-of-day routine, since he was worried she’d missed something during the turmoil of the day. Her head-torch attracted more mosquitoes and other insects, but she had no choice but to use it. There was no electricity as the generator was being saved for emergencies.

Suddenly, Charles appeared. She hadn't seen him coming out of the dark. “Hey doctor, it's time for dinner. Come over to the staff house, you’re invited.” Hanna thought of all the unfinished things on her list and almost told him she had to carry on working. But then she reminded herself of what she had been told repeatedly while preparing to for her stay in Sierra Leone: “If you don't take care of yourself, you’ll get sick or start to burn out, and then your presence won’t benefit anyone. So make sure to get enough rest and recreation”. So Hanna nodded and smiled. “Actually, that's a very nice idea, Charles. Thank you! I’ll be right over after a quick shower”.

By the time she walked to the staff house, the sunset noise of the birds and animals in the forest had already diminished. She looked up and was once again thrilled to see the clear bright stars of

the African sky. Big fruit bats were circling around the mango trees and their silhouettes were mesmerising, yet she still couldn't get the fate of the young mother out of her mind.

Charles welcomed her with a cool beer that she happily accepted. She had promised herself to try to be a patient, easy guest at dinner and not stir the conversation by asking questions about all the things she didn't understand. But again she failed. Shortly after sitting down she found herself bursting out: "Charles, how can this happen? We are all health professionals whether doctors or nurses. Who sends away a woman with obstructed labour just because she cannot pay a small amount of money?"

Charles took a deep breath. He didn't find it easy dealing with these foreign doctors with their naive enthusiasm, and their eagerness to change everything immediately. They always saw things through their particular first-world lens. But he had begun to like Hanna for her positive attitude and the way she always wanted to make the best of every situation, so he had learned to forgive her frankness.

"Don't blame the nurses," he told her. "I have worked in that hospital before. It's a government hospital and they always run out of drugs. There is no proper procurement system. It's absolute chaos and there is no accountability. The members of staff are not being treated fairly so they treat others the same. It's difficult to be a good health worker in those circumstances. Training is lousy and they are overworked. The hospital would need two or three times the number of staff they have at present to cope with the patient load. And many of them don't work there because they have a vocation and are concerned about the health of other people – that's not why they work there. It's because they have to make ends meet – they all have families to feed. In this country, people need to find ways to cope".

Hanna could not and would not accept this explanation: "So you think it is ok to accept that?"

"No, of course not, Hanna, but you have to understand that sometimes there are limits to the choices one can make. On top of that, now with the fear of Ebola, the situation is getting very tense. The government hospitals don't provide their staff with enough PPE (personal protective equipment). Any sick patient meeting the case definition could carry Ebola – and the health workers there don't have sufficient options to protect themselves properly. Especially when it comes to procedures in obstetrics with lots of body fluids involved, that yield high chances of infection... Can one blame them? It is horrible, we are losing a big part of our healthcare workers during this outbreak, because they are at the front line (Exhibit 2). That said, women and children suffer disproportionately, because the epidemic is only decreasing the already insufficient services..."

Hanna stayed quiet. She didn't know how to reply. She felt a need to digest all the new information. In any case, it was getting late and she could barely keep her eyes open. She thanked Charles for the lovely dinner and his attempts to explain everything to her. Still, she would have to think about this for some time. Then she stumbled home through the dark. The fruit bats were gone.

Old friends

She was still too upset to sleep so she wrote to James, an old friend from Sierra Leone whom she had gotten to know during her Master's course on International Health a few years back. She remembered that he had once worked for the Sierra Leone Health Ministry and thus wrote to him asking for some information on the Free Health Care Initiative that she had heard about. After sending the email, she yawned, closed the computer and instantly fell asleep.

The next morning Hanna woke up bright and early. After last night's discussion she was determined to learn as much as she could about the Sierra Leone's health system. She opened her computer – James had already replied!

Dear Hanna!

Good to hear from you – it's been a long time! How are you? Good to know you're in my home country helping our battle against Ebola. I wish I could join you but I am tied up here in Stockholm where I am working on my PhD at Karolinska Institut. We should catch up soon!

To answer your question as best I can:

The Free Health Care Initiative (FHCI) was launched by the government in April 2010 in order to improve common access to key health care services. The main aspect of the initiative was the abolishment of user fees for pregnant women, lactating mothers and children under five.

Alongside FHCI and at the request of the Sierra Leonean government, the UK Department for International Development (DFID) and the Global Fund agreed to top up the salaries of health care workers so that they would receive adequate salaries. This was to make sure health care workers didn't charge the patients for health care services.

According to reports, this initiative has resulted in an increased uptake of healthcare among target groups (pregnant women, lactating mothers and children under five). However, user fees for the rest of the population still exist and there are reports that mothers and children are still being charged for services. According to a 2011 country-wide survey of 1,400 people conducted by the Health for All Coalition Sierra Leone, 20% had been asked to pay for services that should have been free under the Free Health Care Initiative.

One success of the FHCI is a tremendous improvement in monitoring the pay-rolls of health care workers (as opposed to the totally unregulated situation beforehand). This had led to a reduction in the number of 'ghost-workers' (health care workers on the pay role without any actual employment) and a reduction in absenteeism among health workers, even though unauthorised absence rates remain at ten percent.

According to a 2011 Amnesty International Report, one of the major challenges that remain within the FHCI is drug procurement. All drugs need to be imported into Sierra Leone and they enter the country through the port of Freetown. High levels of corruption among the port authorities lead to regular delays in clearing shipments from the port. And there are also still major problems in the distribution of drugs. You know nowadays procurement is a way of making money, and it has ruined the system.

This is all the information I could find for you at the moment – I hope it helps.

Take care of yourself and keep me updated on the latest events!

Yours,

James

“Thanks James”, Hanna thought. “He is reliable as usual.” How she wished he would be in the country and not abroad. To find out more, she googled the Amnesty International report that James had mentioned: ‘At a crossroads – Sierra Leone’s Free Health Care Policy’ (Exhibit 3).

When she had read about half of the report, Hanna looked up. She realised that what she had experienced was probably just the tip of the iceberg – or, as they say in Africa – the ears of the hippo. However, she thought she could understand the situation a bit better now, and wondered how she would behave if she had been a Sierra Leonean national working in this system. Yet, at heart, she was still upset about the woman’s fate and the unnecessary loss of her baby. Suddenly she remembered to look at her watch. Heavens – it was time for work. Gulping down her tepid coffee she dashed to the hospital.

Ebola in the hospital?

When she got to the ward she saw a crowd of nurses together with Charles. They were gathered in a circle, and the discussion sounded a bit heated. “What’s the matter?” she asked. Charles replied without hesitation. “The woman with the fever from yesterday, the one with an initial positive malaria test to which we attributed the fever – it now turns out that she had cared for a dying

family member. When we did the triage yesterday she denied any contact with a suspected or confirmed Ebola case, but now she fits the criteria for a probable case!” Charles was referring to the triage system developed shortly after Hanna had begun working at the hospital. It was based on the official case definition at that time: A probable case of Ebola is defined as someone with fever, at least one other symptom such as vomiting, diarrhoea, headache, muscle ache, abdominal pain, or unexplained haemorrhage in addition to direct contact to a known or probable Ebola case or to body fluids of a known or suspected case of EVD within the past 21 days. It was the first time that a patient already admitted had met the criteria for a probable case.

Luckily, none of the staff members reported any direct, unprotected physical contact with the woman after her fever symptoms had appeared. Their plan now was to quickly move her to the isolation room and disinfect everything with chlorine solution. An ambulance would then collect her for transferral to the Ebola Treatment Unit (ETU) for further tests. This was the procedure that had been decided upon beforehand.

Meanwhile, a crowd of relatives and staff from other parts of the hospital had gathered at the entrance. The news had obviously spread quickly, and now they all feared they might have contracted Ebola and wanted to know what they should do. Charles showed how well he could handle this kind of situation. Based on the guidelines they had previously established, all those who had been in contact with the patient would be closely monitored for 21 days for clinical symptoms and have their temperatures checked twice daily. During that time, they would not be allowed to have any direct contact with patients. The situation was calm as people followed the clear instructions. Hanna was impressed. She had experienced other situations where fear and panic were so overwhelming that rational actions were difficult or impossible. In this hospital, it had obviously helped to develop proper guidelines together with the staff, based on the official recommendations. Hanna wondered whether this may be the exemption rather than the rule.

Effects of the epidemic

Two days later the result came back negative and everyone was relieved. “If only the woman had told us at the beginning about a possible contact with an Ebola patient,” fumed Hanna inwardly, feeling frustrated. “We could have reacted much more effectively and not exposed our staff to this risk!” She began to wonder whether there was any evidence about how Ebola influenced the health-seeking behaviour of the population.

That night, the generator came on and despite her exhaustion, Hanna used the opportunity of the internet connection to do a quick on-line search. She found a UNFPA report on the Ebola impact on reproductive health services and service seeking behaviour:

http://reliefweb.int/sites/reliefweb.int/files/resources/UNFPA%20study%20_synthesis_March%2025_final.pdf.

“This supports exactly what I am seeing here”, thought Hanna. “There is lack of trust in the health system to provide adequate protection to its own staff and users. Additionally, communities report being turned away from facilities, and that they themselves avoid facilities, based on the fear of contracting Ebola. Let’s see, here they state a number: They are projecting an average of 22% more maternal deaths and 25% more newborn deaths during the course of one year!”

Her thoughts continued: "Moreover, mothers do not bring their children to the health facilities for fear that they will be isolated and perhaps not properly treated for a non-Ebola, feverish illness. In this setting of high morbidity and mortality due to malaria, pneumonia and meningitis, I wonder how many more children will die of these diseases just because they are not being brought to a health facility. If I had a sick child in this situation I would probably do the same. I wouldn't want to leave my child alone in isolation..." Hanna sighed. “And my Sierra Leonan colleagues will have to carry on with their work in these conditions for as long as it takes. I really admire them. I will be home after a while, but they may have to put up with this for years. How do you build a strong and resilient health system in this country to start with? And now with the Ebola outbreak on top of that... It’s beyond my comprehension!”

Dinner on the veranda

“Hey Charles, this time it’s me inviting you for dinner! I think we deserve a quiet evening after these eventful days,” Hanna said the next day after her last round in the wards to see whether there was anything else to do. Charles looked up from the charts at the children’s ward and smiled. “Fine, I accept the invitation. When should I be there?”

“Give me one hour!”

When Charles arrived, it had already gotten dark. “Help yourself to a soda, dinner is almost ready,” Hanna shouted from inside the small kitchen. When they finally sat down, Hanna told Charles about what she had learned over the past couple of days. Charles looked down and sighed. “The hospital is almost empty because people are afraid to come here. For them, the hospital is the place to contract Ebola. Fair enough, in many cases that is what has happened. But what worries me

the most is that women have stopped coming here to give birth. At least we are still open, though. In many parts of the country, hospitals have been closed because there was not enough equipment to protect the health workers, and also because health workers have refused to work in these conditions. A friend of mine who works for UNDP is compiling evidence for a report, and he has told me that nationwide deliveries attended by skilled personnel have dropped by 30%. This you can count, but you cannot count all the dead newborns and mothers due to complications...”

Hanna nodded in silence. After a while she added: “What I also find really disturbing, is the huge number of orphans due to Ebola and the way so many families have become more vulnerable. The stigma towards Ebola orphans and survivors is massive, and often they are shunned. Luckily, with more information and awareness this has started to improve, and it is amazing to see how the community and the extended families here have taken in many of the children. But it is hard to imagine how those who could hardly manage before are supposed to cope with this situation over any length of time (<http://www.street-child.co.uk/ebola-orphan-report>).

Charles continued: “You know, Hanna, I am actually a bit upset at the so-called ‘international community’. Years ago we received many regulations to obey, especially from the World Bank and the International Monetary Fund (IMF). This resulted in fewer investments in social and health infrastructure. By the way, have you heard of the Abuja declaration? In 2001, just one year after the Millennium development goals were adopted, the heads of state of African Union countries met and set a target of allocating at least 15% of their annual budget for the health sector (WHO, 2011). At the same time they urged donor countries to fulfil their obligation to pay the 0.7% official development assistance, which the donor countries had committed themselves to (OECD, n.d.). Do you know how many countries are actually fulfilling this? It’s quite frustrating to look at those figures! (<http://odaforhealth.medmissio.de/>) And now, within the Ebola outbreak, the states of the north were so busy with scaring themselves about Ebola spreading to their countries. But why did it take so long for a meaningful response? I am not clear about the role of the WHO either. I always think their guidelines and reports are very useful, but why didn’t they take on a clear role from the beginning of the outbreak? A lot of harm could have been prevented, I think...”

“Charles, that is exactly what I was thinking. And there was one article I read last night that raised a lot of valid points around your question (Exhibit 4). You know, it’s easy to blame the WHO for their failure. But the role of the WHO has been weakened on purpose over the past decades. The agency can only control 20-30% of their funds. The rest is earmarked, and it is mainly channeled to technical interventions, like immunisation programmes. Guess who is the biggest funder of the WHO! No, it’s no longer the US, it’s the Bill and Melinda Gates Foundation. There is no institution controlling this

foundation. They simply set their own agenda, as the biggest single funder of global health (McCoy et al., 2009; Black, 2009). As a matter of fact, the WHO could be the only democratically controlled global health agency, with each of the member countries having one vote. But as I just learned, because of their restricted funds, budget cuts, earmarked funding and the perceived role as a technical agency, we are now far removed from the times of the Alma Ata declaration in 1978 (Gillam, 2008) (http://www.who.int/social_determinants/tools/multimedia/alma_ata/en/).

Hanna continued. “I do, however, agree with you. The ‘international community’ – whatever that means – could have reacted much earlier and been much better coordinated. I think there is a lot to learn from this. On many different levels” (Save the children, 2015).

When Charles had left her house later that evening, Hanna decided to dig deeper into the root causes of the entire situation. She felt a great sense of sadness about it, but also determination. She needed to understand the answers to the questions raised by Charles and herself over dinner, and she wanted to find out more about what could she do herself – as an international doctor working in a small hospital in Sierra Leone.

Discharged into an uncertain future

A day later, the woman who had survived the protracted delivery was stable enough and could be discharged from the hospital. Hanna still felt touched by the woman’s story, and at the same time very concerned. She told her goodbye without shaking her hand because of the ‘no-touch’ policy, and wished her all the best. As they waved to each other, Hanna longed for a way to communicate more with the woman.

Wondering what kind of future lay ahead for her and her children, as well as for her entire family, Hanna stood outside the hospital for a while and watched the woman leave the hospital compound through the gate and walk into an uncertain future.



Serabu Catholic Mission hospital, supported by the NGO German Doctors, was one of the few hospitals in Sierra Leone that continued its services during the entire outbreak. Photo: Eva-Maria Schwienhorst

Exhibit 1

Background information on Sierra Leone for those who have not yet worked on the case
Cultural awareness in times of Ebola.

Sierra Leone

Located in West Africa with its coastline facing the Atlantic Ocean, Sierra Leone shares borders with Guinea and Liberia. These three countries are also known as the Mano River Region. Sierra Leone's capital and political centre, Freetown, is located on a peninsula in the Western Area, while the second largest and economically more important city is Bo, in the Southern Province. Kailahun is situated in the Eastern Province, close to the border with Guinea.

A brief history of Sierra Leone

West Africa was integrated into the Euro-American trade networks from the 15th century. Initially, mainly iron was exported to Europe, but later slaves became the major commodity. During the American Revolution in the late 18th century, a British Colony was established for liberated slaves, named Sierra Leone. Further south, the colony of Liberia was founded to relocate African Americans to Africa from the 1820s. The decades that followed were characterised by violent conflicts between warlords and colonists, as well as migration and flight across the porous border with Liberia.

During the colonial era, political power in Sierra Leone lay in the hands of the British Empire and its appointed leaders. These were chosen by the British Crown for their obedience, and most Sierra Leoneans were barred from participation in politics. All raw materials (agricultural products and minerals) were extracted and exported with the profit going to Britain. No investments were made to improve the livelihoods of the local population, while education was only available to a few.

Independence on 27th April 1961 brought little improvement in the economic situation of the country, and political power continued to be concentrated in a few hands. During the so-called lost years of development in the 1980s, the country was characterised by poor education and failing health systems, a weak economy, high levels of corruption, an untrustworthy political regime (which allowed only a few to benefit from the wealth of the country's resources) and several military coups. All this culminated in a civil war that lasted from 1991 to 2002 – claiming 50,000 lives. It also resulted in 4,000-10,000 amputees, 70,000 former combatants, many child soldiers and an entire nation traumatised (Christodulou, 2004, p.9, par. 48; Fairhead, 2014, chap.2; Menzel, 2015, p.40).

The economy

During the early 2010s, Sierra Leone was one of the fastest growing economies in Africa, its main sectors being agriculture and mining, especially of iron ore and bauxite. Nevertheless, Sierra Leone remained one of the poorest countries in the world as it continued to deal with the aftermath of civil war and high rates of corruption. The 2013 Human Development Index ranked Sierra Leone 184th out of 187 countries in the world. Power and wealth continue to lay in the hands of the country's elite and foreign companies (Central Intelligence Agency (CIA), 2014; Menzel, 2014).

The health system

In a report published in 2011, Amnesty International states that “Sierra Leone’s health system is characterised by a poor infrastructure, a lack of appropriately qualified health care workers, and insufficient supplies of drugs and equipment. Even the best government hospitals in Sierra Leone often lack running water, electricity, and other basic necessities. These problems are exacerbated by poor co-ordination, management and oversight of the health system” (Amnesty International, 2011, p 11).

Ethnic groups

About 18 ethnic groups refer to Sierra Leone as home, although all of them have their own language and customs. African tribes account for the majority of the population. These include the Temne, Mende, Limba, Fula, Kono, Mandinga, Kuranko, Loko, Susu, Yalunka, Kissi, Vai, Kru, and Sherbro. The Temne and Mende are the two largest groups representing 35% and 30% of the population respectively, while the descendants of freed Jamaican slaves (the Krio/Kriole) account for 10%. A small number of Lebanese, Indians and Europeans also live in the country (United Nations (UNIPSIL), n.d.); Central Intelligence Agency (CIA), 2014).

The Ebola outbreak

The 2014 Ebola outbreak in West Africa was the 25th known event since 1976 and by far the largest and longest. According to the World Health Organisation (WHO), it represented a “public health emergency of international concern” (Piot et al., 2014, p.1034); (WHO, 2014d).

Ebola Virus Disease (EVD) is a severe illness caused by a Filovirus called Ebola. An infectious, rapidly fatal disease with a death rate between 50% and 90% and no causative treatment thus far, it is spread through direct contact with bodily fluids (blood, saliva, urine, sperm, etc.) of an infected person, as well as through contact with contaminated surfaces or equipment, including linen soiled

by the bodily fluids of an infected person. The time interval between exposure to bodily fluids and development of symptoms is 2 to 21 days with an average incubation time of 8 to 10 days. It is important to note that an infected person is only contagious when he or she has already developed symptoms. The person suffering from EVD is most infectious during the last stage of infection, and immediately after death (Richards and Fairhead, 2014, n.4; CDC, 2014a; CDC, 2014b; CDC, 2014c; WHO, 2014a).

The outbreak began in Guinea in December 2013, although the WHO was not officially notified before 23rd of March 2014. During the epidemic, the EVD mainly spread across Guinea, Sierra Leone and Liberia with a few isolated cases reported in Mali, Nigeria, Senegal, Spain, the UK and the US. However, in these latter countries an epidemic was preventable through infection control measures. During 2014 the number of cases rose to 20,206 with 7,905 deaths reported by 31st December 2014. The WHO assumed a significant level of under-reporting and the number of cases was believed to be higher. It was anticipated that the number of people who contracted the virus would continue to rise in 2015 and by 10th May 2015 26,759 cumulative cases and 11,080 cumulative deaths had been reported. Thereafter, there was a rapid decline in the number of registered cases (WHO Ebola Response Team, 2014, p.1482; WHO, n.d.; WHO, 2015a). On 9th May 2015, after a period of 42 days since the last case had been reported, the outbreak was officially declared over in Liberia, while new cases still occurred in Guinea and Sierra Leone. In July 2015, however, new cases were again registered in Liberia (WHO, 2015b).

The countries that were the most affected (Guinea, Sierra Leone and Liberia) were confronted with enormous problems in trying to stop the epidemic. Throughout the early months of the epidemic national governments denied the outbreak, while the response was too slow and inefficient. As the first international organisation on the ground, Médecins sans Frontières (MSF) established the first Ebola treatment units in Guinea and in Kailahun, Sierra Leone. When the governments and WHO finally acknowledged the magnitude of the outbreak and multi-national and multi-sectoral efforts were mobilised to implement control measures and provide clinical care for people with EVD, it took considerable time and effort to bring the epidemic under control (MSF, 2014).

Over the course of the epidemic, many different methods were put in place in an attempt to halt the spread – with very different success rates: from a relatively late scale up of ETUs (Ebola treatment units) and putting entire districts under quarantine, legally banning traditional burial ceremonies and arresting those who did not comply to mass awareness campaigns, to community based care and the involvement of traditional and religious leaders and anthropologists (See Case *Cultural awareness in times of Ebola* for more information).

Sierra Leone: Facts and figures

Human Development Index (HDI)	Rank 183 (2013) out of 187 countries (UNDP, 2014)
Population	5,743,725 (July 2014 est.)
Urbanization	urban population: 39.2% of total population (2011)
	Rate of urbanization: 3.04% annual rate of change (2010-15 est.)
Median age	Total 19 years
	Male 18.5 years
	Female 19.6 years (2014 est.)
Religion	60% Muslim
	10% Christian
	30% indigenous beliefs
Birth rate	37.4 births/1,000 population (2014 est.)
Death rate	11.03 deaths/1,000 population (2014 est.)
Mother's mean age at first birth	19 years
Total fertility rate	4.83 children born/woman (2014 est.)
Maternal mortality rate	890 deaths/100,000 live births (2010)
Infant mortality rate (< 1 year)	73.29 deaths/1,000 live births
Life expectancy at birth	total population: 57.39 years
	male: 54.85 years
	Female: 60 years (2014 est.)
Physicians' density	0.02 physicians/1,000 population (2010)

Sanitation facility access	improved	unimproved
	urban: 22.5% of population	urban: 77.5% of population
	rural: 6.8% of population	rural: 93.2% of population
	total: 13% of population	total: 87% of population (2012 est.)
HIV adult prevalence rate	1.5% (2012 est.)	
Education expenditures	2.9% of GDP (2012)	
Literacy	Definition: age 15 and over can read and write English, Mende, Temne or Arabic	
	Total: 43.3%	
	Male: 54.7%	
	Female: 32.6% (2011 est.)	
School life expectancy (primary to tertiary education)	Total: 7 years	
	Male: 8 years	
	Female: 6 years	
Child labour – children ages 5-14	Total number: 573,287	
	Percentage: 48% (2005 est.)	

(Central Intelligence Agency (CIA), 2014)

Exhibit 2

Graphs with additional health data

Table 1 Basic public health data

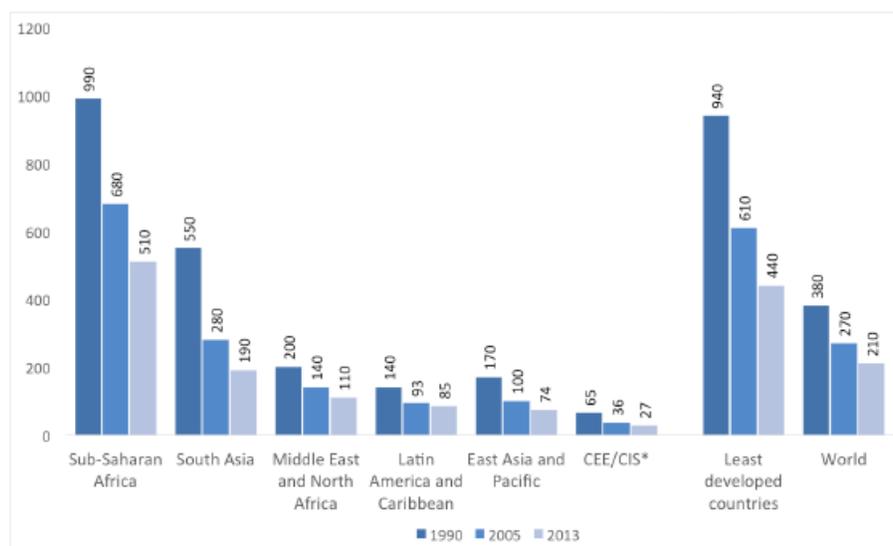
	Sierra Leone	Liberia	Guinea	African region
Percentage of population using an improved sanitation facility (2012)	13	17	19	33
Percentage of population using improved drinking water sources (2012)	60	75	75	66
Percentage of children under 5 years with stunting (2006–12)	44.9	41.8	35.8	39.9

Source: World Health Statistics (2014).

Table 2 Basic health system data for 2011

	Sierra Leone	Liberia	Guinea	African region
Physician density per 10,000 population	0.2	0.1	-	2.6
Nursing/midwife density per 10,000 population	1.7	2.7	-	12
Total health expenditure as % GDP	16.3%	15.6%	6.0%	6.2%
Health expenditure per capita at average exchange rate (US\$)	\$192	\$92	\$27	\$99
Gov't health expenditure as percentage of total	16.2%	29.7%	24.3%	48.3%
Private health expenditure as percentage of total	83.8%	70.3%	75.7%	51.7%
External funding as percentage of total health expenditure	18.2%	29.5%	12.2%	11.8%
Out-of-pocket expenditure as percentage of private health expenditure	91.4%	30.0%	92.7%	56.6%

Source: World Health Statistics (2014).



Source: *Maternal Mortality in the world* (UNICEF, 2014)

Table 5: Ebola virus disease infections in health workers in Guinea, Liberia and Sierra Leone

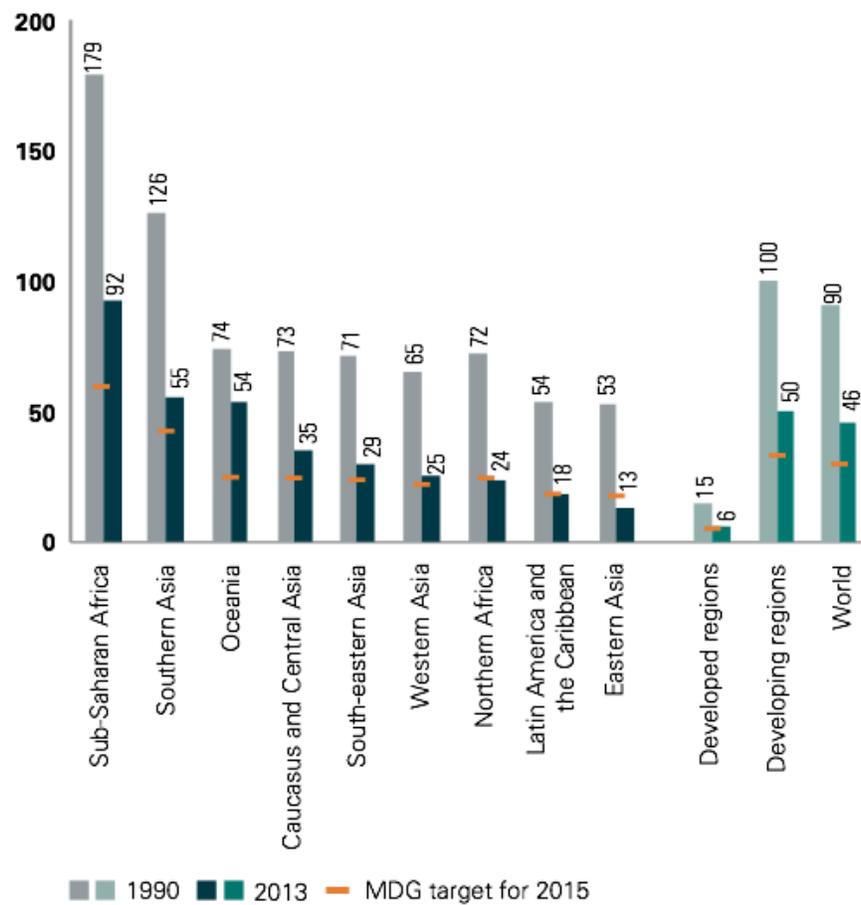
Country	Cases	Deaths
Guinea	187	94
Liberia*	378	192
Sierra Leone	303	221 [‡]
Total	868	507

Data are confirmed cases and deaths only, apart from deaths in Sierra Leone, which include confirmed, probable, and suspected deaths. *The outbreak in Liberia was declared over on 9 May. ‡Data as of 17 February

Source: WHO Ebola Situation Report May 13, 2015

FIGURE 1 Under-five mortality declined in all regions between 1990 and 2013

Under-five mortality rate, by Millennium Development Goal region, 1990 and 2013 (deaths per 1,000 live births)



Source: Under-5 Mortality in the world, (UNICEF, n.d.)

FIGURE 2
Neonatal mortality rate is declining in all regions

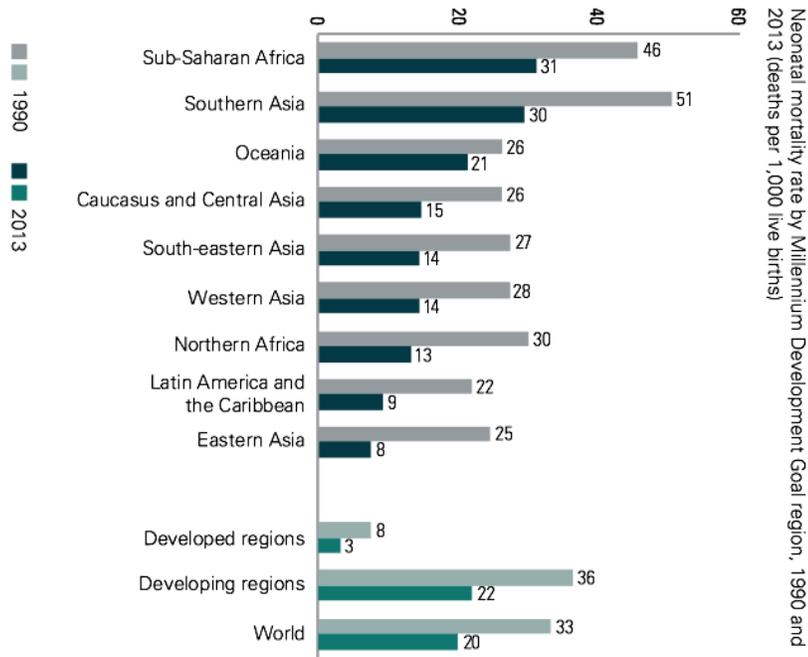
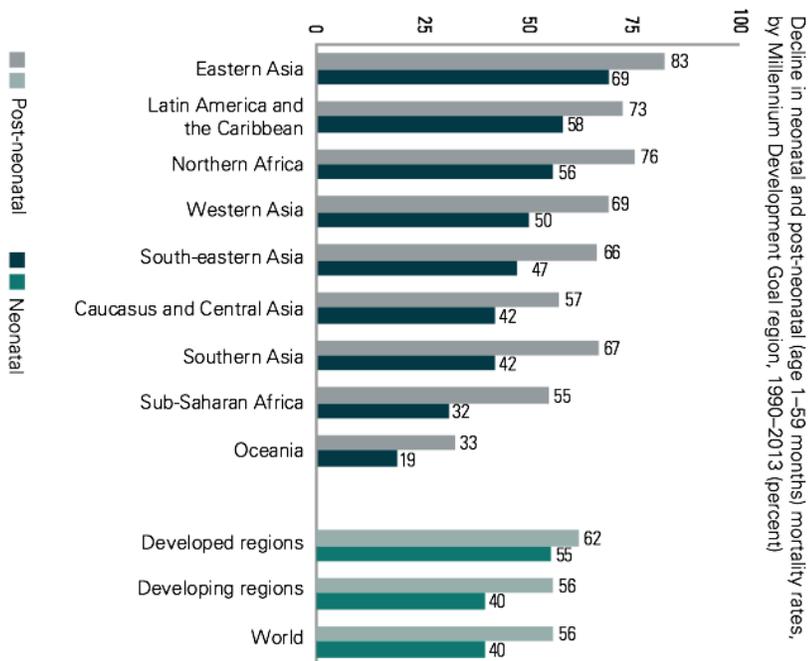


FIGURE 3
The decline in the neonatal mortality rate has been slower than the decline in the post-neonatal mortality rate in all regions



Source: Levels and trends in child mortality, (UNICEF, 2014)

Exhibit 3

At a crossroads – Sierra Leone’s Free Health care policy

Excerpts from a report by Amnesty International published in 2011:

“Sierra Leone’s health system is characterized by poor infrastructure, a lack of appropriately qualified health care workers, and insufficient supplies of drugs and equipment. Even the best government hospitals in Sierra Leone often lack running water, electricity and other basic necessities. These problems are exacerbated by poor co-ordination, management and oversight of the health system.

In 2009 Amnesty International published a report, “Out of Reach: The Cost of Maternal Health in Sierra Leone”, that highlighted the range of barriers faced by pregnant women while trying to access emergency obstetric care services. Amnesty International called on the Government to remove financial barriers to accessing health care, and in particular emergency obstetric care, and to ensure that such care is available and equitably distributed throughout the country.

(...)

The launch of the Free Health Care Initiative constituted a leap forward and inspired hope in people. However, the move from policy to tangible change for people using the health service has been difficult. While the government has tried to address some of the underlying and systemic problems, others remain un-examined and un-addressed. One of the central problems is the lack of effective systems of monitoring and accountability. This is the focus of this report which aims to highlight how strong and effective systems for monitoring the delivery of the Free Health Care Initiative are one of the keys to delivering the promised health impacts.

(...)

Women and girls report two significant problems with the FHCI: either drugs and other essential medical supplies are simply not available at the health facilities, or they are charged for medicines and care that are supposed to be provided for free. Often, when essential drugs for women in pregnancy and childbirth are not available for free, they are available for a price – in the same facility - as “cost recovery” drugs. Women described how they were sent to private pharmacies to buy drugs, and being told that drugs and consumables (such as needles, synergies, plasters) were available but only for sale. In cases where they were not able to pay the charges they were simply denied the care or the medicines.

(...)

In summary, monitoring systems are either poorly resourced or non-existent. What systems do exist are characterized by a multitude of actors without clear responsibility, poor management, planning, funding, and capacity. Such a system provides some people with the opportunity to exploit the deficiencies in the system and take unscrupulous advantages.

(...)

The continued lack of recognition of the right to health remains a major obstacle to women and girls accessing remedies. As explained by a representative of a civil society organization: There is no culture of accountability. Health is not considered as a human right, most government officials think that it is a service they provide...But the problem is more complex in relation to maternal mortality, so many women die while giving birth, people don't think it is a violation of human rights. There is also an issue with the legal system, people do not trust it. The Legal Aid bill has been pending for years now.“

Amnesty International: *At a Crossroads: Sierra Leone's Free Health Care Policy*, 6 September 2011, AFR 51/001/2011, available at: https://www.amnestyusa.org/sites/default/files/pdfs/sierral_maternalrpt_0.pdf [accessed 16 March 2015]

Exhibit 4

Ebola – a crisis in Global Health leadership

Excerpts of an article by L. Gostin and E. Friedman, October 2014:

“The WHO, with its budget and capacity to respond diminished, has largely been sidelined in the response to Ebola. In a leadership vacuum, high-income countries sent in military assets, the UN Security Council declared Ebola a threat to international peace and security, and UN Secretary-General Ban Ki-moon created a special UN mission. How did this situation arise, and what will it take to bring Ebola under control and prevent future crises? The answers lie in failures of leadership. WHO should be the global health leader. Under its constitution, WHO was envisaged as “the directing and coordinating authority on international health work”. In describing WHO’s mission recently, however, Director-General Margaret Chan said it is a “technical agency”, with governments having “first priority to take care of their people”. Yet the affected states possess fragile health systems that have proven unable to prevent Ebola’s domestic and transnational spread. WHO itself is constrained. Its budget is incommensurate with its responsibilities, with an operating budget a third of the US Centers for Disease Control and Prevention’s budget. After a 2011 funding shortfall, WHO cut its already insufficient budget by nearly US\$600 million.

The organisation’s emergency response units were reduced, with some epidemic control experts leaving the agency. Furthermore, WHO controls only 30% of its budget, and member states have co-opted WHO’s agenda through earmarked funds.

(...)

WHO declared Ebola a PHEIC on Aug 8, triggering temporary non-binding recommendations. Some countries imposed travel bans, contrary to WHO’s recommendations. Affected states, moreover, could not realistically implement WHO recommendations for treatment centres, health worker compensation, and personal protective equipment.

(...)

The delayed and fragmented response to Ebola left a vacuum, which led to an unlikely plea from Médecins Sans Frontières for military deployment—logistics, engineering, and supply-chain management. On Sept 16, US President Barack Obama announced a military-led response in Liberia, which could shore-up capacity but will not fill major governance deficits, which require UN action.

The UN has the legitimacy and authority that nation states lack. The UN Security Council is charged with maintaining international peace and security and, under article 25 of the UN Charter, member states are required to carry out its decisions. The Security Council’s Sept 18 resolution on Ebola was the second time it had responded to a health crisis, after HIV/AIDS resolutions in 2000 and 2011. The Security Council concluded the Ebola epidemic could reverse peacekeeping and development gains, at a time when Liberia and Sierra Leone are recovering from destructive civil wars and a UN peacekeeping mission remains in Liberia. The unanimous resolution called on member states to deploy medical assets, expand public education, and end travel bans. Although the resolution left unclear the exact duties required of states, the Security Council powerfully urged state action, while raising the political profile of Ebola in ways WHO could not.

(...)

The Ebola crisis should become a turning point for WHO reform, and for its member states being willing to fully resource it. No agency can exert leadership when it controls only a small portion of a depleted budget. The World Health Assembly should substantially increase members’ assessed contributions, create an emergency contingency fund, reform its regional organisation,

and engage non-state actors. Along with supportive member states, strategic leadership requires an organisational ethos that embraces WHO's promise as the leading global health authority. WHO's mission is tied to national health capacities, so it should negotiate an international health systems fund. A bolder vision would be a Global Fund for Health.

Failures in leadership have allowed a preventable disease to spin out of control, with vast harms to social order and human dignity. If the Ebola epidemic does not spur major reforms, it will undermine the credibility of WHO and the UN, and enable the conditions for future crises to persist. Major failures in governance and leadership could be repaired if lessons are learned from Ebola. The UN Secretary-General and WHO Director-General should jointly commission a high-level independent commission to review what went wrong and how to prevent future global health emergencies. The commission's mandate should include: ample resources and political will to fulfil WHO's global mission; effective functioning of the IHR; the UN's responsibilities in a global health emergency; sustainable health system financing; calibrating the military's role when public health is overwhelmed; and scientific research and ethical allocation of vaccines and medicines.

The world needs a strong WHO, with the financing and political influence to fulfil its historic mission. The Ebola outbreak should push political actors to enact the far-reaching reforms needed. Global health leadership can be built, but only if genuine leaders choose to build it.

Gostin, L.O., Friedman, E.: *Ebola: A Crisis in Global Health Leadership*. SSRN Scholarly Paper No. ID 2509858, 2014. Social Science Research Network, Rochester, NY.

Available at: <http://download.thelancet.com/flatcontentassets/pdfs/S0140673614617918.pdf>