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Infectious Injustice: The political foundations of the Ebola crisis in Sierra Leone

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Abstract: This article identifies the long-term political factors that contributed to the Ebola crisis in Sierra Leone, which are largely overlooked by the emerging international focus on building resilient health systems. We argue that the country exhibits critical symptoms of the recurrent crises of a gatekeeper state, including: acute external dependency, patron-client politics, endemic corruption, and weak state capacity. A coterie of actors, both internal and external to Sierra Leone, has severally compromised the health system. This left certain sections of the population acutely at risk from Ebola and highlights the need for political solutions to build stronger, inclusive health systems.

Keywords: Global health, health systems strengthening, Ebola Virus Disease (EVD), gatekeeper state, patronage politics, Sierra Leone

Introduction

According to the World Health Organisation (WHO), one of the core reasons the Ebola Virus Disease (EVD) spread so extensively in Sierra Leone, Liberia and Guinea was that their health systems 'lacked resilience' and that as a result, 'when the crisis struck, the countries had no reserve capacity to mount an effective and timely response.' The WHO argued that these countries' health systems suffered from particular structural weaknesses, including an insufficient number of health workers who were poorly distributed across the country, and inadequate surveillance and information systems for oversight. The report identified further weaknesses such as 'absent or weak rapid response systems, few laboratories mainly located in cities, unreliable supply and procurement systems for PPEs [personal protective equipment] and other supplies, lack of electricity and running water in some health facilities and few ambulances.'[1]

This article focuses on Sierra Leone where the number of infections eclipsed the other countries (reaching 13,683) and new cases continue to be reported in September 2015.[2] Indeed, the weakness of Sierra Leone's health infrastructure was exposed by the EVD epidemic. Hospitals were already understaffed and under resourced to cope with everyday health challenges, including maternal health and endemic Malaria. In 2008, there were only 95 physicians and 991 nurses and midwives, equating to 2 physicians and 18 nurses and midwives per 100,000 people.[3] As a result, some of Sierra Leone's health indicators, including life expectancy (45 years) and death rate (17 per 1000 people), remain persistently among the worst in the world.[4]

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The international community's response to the EVD epidemic was to promote a containment strategy. The President of Sierra Leone, Ernest Bai Koroma, ordered the quarantine of EVD 'epicentres' and military personnel were deployed to establish roadblocks, and clinics were built to try and isolate infected people.[5] The UK was among the countries leading the international response, which was directed largely by its armed forces with the support of health organisations such as Medecins Sans Frontieres (MSF). The virus was eventually contained and by August 2015 a successful trial of the VSV-EBOV vaccine was hailed as a 'game-changer' by one Assistant Director-General of the WHO.[6]

However, the eventual success of the containment strategy should not provoke celebration but instead a prolonged period of detailed introspection among the actors involved. Indeed, the scale of the crisis is argued to present an opportunity to galvanise renewed commitment to long-term health systems strengthening (HSS). In this vein, the WHO Executive Board on the Ebola Emergency argue that 'Media interest, technical support, and financial resources have surged into these countries. This creates a *window of opportunity* for reinforced action on health systems strengthening that lays the groundwork in the affected countries for universal access to safe, high quality health services'.[7] This sentiment is echoed by those on the ground who led the emergency response, including the head of the MSF mission in Sierra Leone, who contends that

> It is clear that the work to improve healthcare in Sierra Leone will not end with the epidemic. Even before Ebola, Sierra Leone suffered from an acute shortage of skilled staff, limiting access for the population to key life-saving services. After the loss of more than 220 health workers to Ebola, there is a real need, not for just funding and promises, but for skilled clinicians on the ground across the country.'[8]

Building more resilient health systems has thus become almost an article of faith for international donors and NGOs.[9]

Our concern here is with the need to broaden the scope of these reflections to include a focus on the political foundations of the EVD epidemic.[10] In short, the task before us is not simply to enhance short-term resilience to health crises, but to tackle the very roots of endemically weak health systems in the first place. The IR scholarship and much of the Global Health scholarship more specifically are traditionally ill-equipped to respond to this challenge: as Harman and Brown argue, this is not simply a question of Africa's omission,[11] but there is often disconnect between the 'discipline's theoretical constructs and Africa realities'.[12]

We will elucidate below how the weakness of the health system reflects an extreme manifestation of the recurring political crises afflicting many of Africa's 'gatekeeper states', including: acute external dependency, patron-client politics, endemic corruption, and a weak state unable to provide basic services and protections to its population.[13] Since the country's devastating civil war (1991-2002), the country has become what Harris describes as a 'laboratory' for liberal experiments in state building and governance.[14] We argue that as powerful external actors endeavour to protect their investments and decentralise power, the creation of multiple parallel health systems complicate health provision and entrench dysfunction. Within this context, the potential for rent-seeking among politicians and local health professionals is particularly acute in a sector that attracts such high volumes of external resources. The lack of capacity for oversight has reproduced an environment in which local actors invert external interventions – including, in this case, those designed to the contain EVD epidemic - for private gain. Therefore, while the vast majority of Sierra Leoneans working to combat the spread of EVD have done so with great courage and at considerable personal risk, the rent-seeking behaviour of some government officials and

health care professionals has nonetheless diverted substantial resources away from this effort. Furthermore, the manner in which the epidemic spread in Sierra Leone highlights the structural violence that permeates society: where social structures (including economic, political, legal, religious, and cultural structures) engender inequality, they prevent individuals or groups from achieving their full potential and expose them to risk.[15]

The core challenge ahead remains to augment stronger, inclusive health systems. While the latest emphasis on health system 'resilience' may help contain future outbreaks, such a focus ultimately reflects a desire to manage the public health risks generated from the fallout of late capitalism and the global inequities that it produces. Broad-based HSS, on the other hand, is a much more ambitious project of social transformation tackling, as best it can, the roots of structural violence. This requires long-term commitment to finding political solutions to health problems that address the reasons why populations are at risk in the first place.

The recurrent crises of the gatekeeper state

Like their colonial predecessors, Africa's post-colonial elites often struggled to extend their power and control over the entirety of their states. First, these states were weak from their very inception owing to seemingly arbitrary demarcation of their borders, which reflected the European colonial rivalries of the late nineteenth century, rather than the political and social realities of African societies. Second, Africa's post-colonial leaders inherited economies that had been orientated towards servicing external demands for African resources and rarely generated sufficient economic growth to sustain industrial diversification or an expansionary fiscal programme that was not entirely dependent on external aid, loans and other forms of development assistance. As Cooper notes, a 'gatekeeper state' complex therefore prevails in many Africa states. Political elites in office attempt to reproduce their power as best they can by controlling the internationally recognised state (the 'gate') and regulating access to the resources channelled into it from outside, including the allocation of development assistance, jobs, status, authority, and access to markets.[16] Public resources are thus distributed in a private, discretionary fashion as a form of political patronage in exchange for political support. Beresford argues that the kind of 'gatekeeper politics' that emerges 'is therefore not synonymous with corruption, though corruption is a pervasive symptom of it. Instead, it reflects something much broader: political and social structures through which authority and power are cultivated, disseminated, and contested.'[17] It is important to recognise that this kind of patronage-based political system is not a uniquely "African" form of political aberration and breakdown, however.[18] Furthermore, scholars have noted the need to be careful to identify the varying degrees to which such politics prevails across different African countries and the different forms it can take, which can in large part depend on the strength of the central state and the dynamics of capitalist development in each particular state. [19]

We will argue here that Sierra Leone exhibits one of the more extreme manifestations of the 'recurrent crises' described by Cooper that afflict some of Africa's gatekeeper states, which we characterise as having several interconnected symptoms:

- a weak economy premised primarily upon primary resource extraction
- external dependency on international resources
- volatile gatekeeper politics based on political patronage producing a weak state vulnerable to political upheavals
- a state unable to provide basic services or perform basic social functions for the population

Such an analysis stands in contrast to an emerging narrative among Western donors and investors celebrating 'Africa's rising', pointing to a continent of 'hopeful economies' exhibiting relatively high levels of GDP growth rates, emerging middles classes and an increasingly large market of African consumers.[20] This narrative has also been embraced,

with considerably less credibility, to celebrate Sierra Leone's recent economic record since the war, including GDP growth of over 20 per cent before the EVD epidemic.[21] The country's most recent Poverty Reduction Strategy Paper (PRSP), the 'Agenda for Prosperity (2013 – 2018)', aims to build on what it calls the 'tremendous progress' achieved as a result of the previous 'Agenda for Change (2008-2012)' and contribute towards Sierra Leone's 'epic journey to become a middle income country.'[22] While mindful of the challenges that still confront the country, the World Bank has consistently noted the 'remarkable strides and reforms' the country has witnessed since the end of the civil war in 2002, and that as a result of its recent programmes of reform, 'progress has been made, albeit at different levels, on most indicators of growth, poverty, MDGs, fragility, investment climate, and governance'.[23]

The 'Africa rising' narrative contains severe deficiencies, however. As Taylor notes, 'the dynamics which are accompanying a notional "rise" of Africa' are 'actually contributing to the continent being pushed further and further into maldevelopment and dependency'.[24] Sierra Leone has historically been endowed with natural resources including iron ore, titanium ore, bauxite cocoa, rutile, diamonds, and also relatively fertile land with plenty of rainfall. However, as Zack-Williams observed back in the 1980s, little had been achieved since independence to diversify the economy and decrease the dependence on primary resource exports.[25] Indeed, Sierra Leone's recent growth is underpinned by a continued dependence on exporting iron ore in particular,[26] highlighting the country's narrow export base and its vulnerability to changes in the terms of trade.[27] Little has therefore been achieved in terms of the long-term structural transformation of the economy and, as the IMF has recently argued, the recent 'twin shocks' of the EVD epidemic and a sharp drop in iron ore prices have 'dealt a severe blow' to this dependent economy.[28] What growth has been achieved has done little to generate a sustainable tax base that could underpin an expansionary state agenda and Sierra Leone remains acutely dependent on external resources, which account for 80 percent of gross national income and reflect more than double the amount of annual government expenditures.[29]

Furthermore, Mkandawire argues that it is not simply the presence of growth alone that confirms Africa's 'rise', and that we should remain critical of the kinds of economic growth that is taking in place, particularly when this exacerbates vast inequalities and social stress.[30] Despite rapid economic growth in Sierra Leone, any notion that this has 'trickled down' to the poorest in society is highly questionable. Sierra Leone continues to have some of the worst development statistics in the world and glaring social inequalities. 53 percent of the population were living below the poverty line in 2011 and this was particularly acute in rural areas, at 66 percent. It ranks close to the bottom of the Human Development Index (HDI), which assesses long term progress in living a long and healthy life, access to knowledge and a decent standard of living. 77 percent of the population are living in multidimensional poverty, in that they experience multiple deprivations in education, health and standard of living.[31] Furthermore, rural populations, the poor, youth and women bore the brunt of the negative implications of externally-supported neoliberal Structural Adjustment Programmes (SAPs).[32]

While relations of global dependency have undoubtedly contributed to Sierra Leone's enduring political and social crisis, we should nonetheless be careful not to overlook or downplay the manner in which African elites have participated in the processes which have inserted African societies as dependent partners in the global economy, as well as the manner in which the prominence of patron-client relations have exacerbated inequalities within these societies themselves.[33] Harris argues that from the outset, the under-resourced colonial state was forced to forge linkages with traditional institutions such as the chieftaincy and to distribute the resources of the new state as a form of patronage in exchange for their loyalty.[34] Indeed, authors have long observed the distribution of public goods in Sierra Leone within

private networks of political patronage and how this has remained an enduring feature of elite survival strategies since independence.[35] Reno argues that these patrimonial networks have remained essential to the exercise of power by the post-colonial elites through what he describes as the 'shadow state': a dense collection of 'informal commercially orientated networks' between global and local actors which operate alongside official government bureaucracies and formal state structures.[36] Indeed, a ubiquitous feature of Sierra Leonean politics – like so many African states - has been entrenched structural violence in which livelihoods are premised upon the quality of access to these private, informal channels of resource and opportunity distribution controlled by a coterie of gatekeepers strategically placed within the parallel realms of authority of the state bureaucracy and traditional institutions like the chieftaincy.[37]

By the early 1990s this form of gatekeeper politics became increasingly volatile. Economic decline and endemic corruption generated a crisis for the state as the resources available for patronage networks began to dry up.[38] The state elites responded by assuming an increasingly predatory and violent posture in relation to the wider population, and the state's retreat from offering even basic social services to the population magnified existing social exclusion, generating resistance and, eventually, rebellion.[39]

By the time the war ended in 2002, the country's already weak infrastructure and governmental capacity had been decimated. International attention was focused on Sierra Leone's post-conflict reconstruction, making it a 'test laboratory' for liberal peace-building.[40] However, the economy is still heavily dependent on the outside world and the relatively small incomes it receives from the enclave extraction of minerals and, as discussed above, little has been achieved to address this. Despite intensified liberal interventions promoting greater accountability and anti-corruption campaigns, political elites have proved remarkably adept at balancing donor demands for good governance and neoliberal reforms with the political prerogative of managing access to donor resources to further their political survival.[41] According to Transparency International, Sierra Leone was ranked 119 out of 175 territories and countries and scored 31 out of 100 in the Corruption Perceptions Index (2014) based on data from expert and business surveys.[42] Meanwhile, donors have supported the state's attempts to re-establish the powers of the traditional authorities (particularly the paramount chiefs) as part of efforts to promote the decentralisation of authority and encouraging local accountability. While these traditional authorities enjoy a degree of legitimacy among Sierra Leoneans, there are widespread concerns that they will continue to play the role of local gatekeepers whose discretionary control over access to resources and opportunities can reproduce social exclusion for those not included within their networks of patronage.[43]

This brief account of Sierra Leone's political and economic fortunes therefore offers little to support the celebratory tone of the 'Africa rising' commentary. Instead, it offers an insight into a particularly acute manifestation of the recurrent crises of the gatekeeper state. The concern for the rest of this paper is how this contributed not only to the weakness of the state, and the consequent weakness of the country's health system, but also to the structural violence experienced by its population that enabled the virus to spread so rapidly.

A dependent health system in crisis

In 2012 the WHO offered an optimistic outlook for Sierra Leone's health system, arguing that 'macroeconomic stability and economic growth will help reduce poverty, increase equity and enable the Government of Sierra Leone to allocate additional resources to the health sector'.[44] However, once again, the limitations of this *a priori* assumption that economic growth would necessarily contribute to improving health provision are revealed when one

analyses the enduring symptoms of the gatekeeper state crisis in Sierra Leone and the impacts this has on the health sector.

First, the health sector is acutely dependent on external aid. In 2007, 78 per cent of resources were derived from external sources, with 12.9 million USD (42 percent) coming from the UK's Department for International Development (DfID). The other key donors include the Global Fund, World Bank, Asian Development Bank, UNFPA and UNFPA. Despite the 15 percent pledged by the Abuja Declaration, the Ministry of Health and Sanitation (MoHS) receives only 8 percent of the government's budget. Core health initiatives are heavily dependent on external funding in the absence of sufficient government resources, such as the government's Free Healthcare Initiative (FHCI) to address maternal and infant health, which attracted considerable external resources: 87 per cent of the estimated $35m USD cost was funded by the development partners.[45]

As a result of this dependency, the government's control over the health sector is severely compromised, as is its ability to set and coordinate a coherent health agenda at the national level. The government is influenced by the 'swinging pendulum'[46] of the constantly shifting priorities from the international donors and has to remain malleable to embracing externally defined health agendas, including the Alma Ata Declaration, the Ouagadougou Declaration, the Millennium Development Goals and the IMF/Bank PRSPs. Donors have promoted decentralisation and anti-corruption campaigns as a way of combating the misuse of funds in the health sector and increasing accountability.[47] Meanwhile, NGOs often attempt to circumvent the state due to fears over corruption by funding and delivering individual projects according to their own priorities. This has led to the fermentation of multiple parallel health systems, some funded and managed through the government and others run by traditional healers, Faith-Based Organisations, international and local NGOs and also civil society organisations, which are often entirely reliant on either external funds or collecting private service fees. For example, Gavi, the global Vaccine Alliance for creating equal access to new and underused vaccines, represents another major funder in the health sector since 2001. With 23.2m USD of direct funding for vaccines and 4.1m USD of cash-based support including for Immunisation Services Support (ISS) since 2001 and Health Systems Strengthening (HSS) from 2008.[48] Despite the suspension of Gavi funding channelled through the state in 2012 due to fears about corruption, considered further below, Gavi itself continued to provide vaccines through alternative supply mechanisms and in other instances DfID directly funded health workers' salaries rather than channelling assistance through the government.[49] These parallel structures of health care management and delivery have generated complexity and in some cases dysfunction, draining time and resources and reducing the capacity for oversight. For example, the Ministry of Health's 'National Health Sector Strategic Plan' identified 'weak sector coordination structures and arrangements at all levels' between health service providers, 'weak public private partnership (PPP) in the provision of comprehensive integrated health services' and also 'weak mechanisms for public accountability.'[50] The government reports that a lack of harmonisation leads to 'fragmented individual projects', unpredictability, duplication, and a general lack of accountability.[51] Amnesty International also reports on the problems these parallel health systems present, arguing that 'the lack of monitoring and oversight within the system has created a context where corruption can flourish'.[52]

Second, as Brown notes, while the power imbalance between donors and African elites in office can severely curtail the state's autonomous control over policy, it is important to understand that this does not mean the entire 'politico-legal independence' of the state is being challenged.[53] Instead, we have to examine the manner in which state actors compensate for their limited power through navigating and even exploiting their external dependency; what Bayart refers to as the 'strategies of extraversion' – putting on a show of compliance

with external agendas in order to preserve the flow of resources into the country.[54] African state and non-state actors can play up their situations of dependence, problems and poverty as leverage for attracting resources.[55]

In this respect, even though the capacity for autonomous policy action and initiatives in the health sector is restricted by external agendas, rent-seeking opportunities are abundant. This is because considerable amounts of resources are directed into the health sector. For example, international concerns with 'HIV exceptionalism' generated considerable donor attention and funding for HIV/AIDS prevention and care (despite the low, stable prevalence) at the expense of tackling more pressing health challenges. In response, the Sierra Government (and some citizens) exaggerated this presentation of the country as one suffering from HIV in order to preserve this lucrative flow of resources for their own benefit.[56]At the same time, the complexity of health care provision undermines accountability by limiting processes for monitoring and evaluation. It is also, of course, a sector which is too significant to fail, and a complete cessation of funding would be politically unfeasible for donors. This has generated some high-profile corruption scandals. For example, in March 2010, the former Minister of Health, Sheiku Tejan Koroma, was convicted for abuse of office, abuse of position and failure to comply with procurement procedures.[57] Even this seeming crackdown presented an opportunity in itself. With respect to the indictment of the Minister in 2009, for example, a cable from Freetown to the Economic Community of West African States (ECOWAS) suggests it was a strategy of extraversion:

> Sources told the Political Section that Koroma's indictment appears deliberately timed to make a good impression on the donors before the Consultative Group meeting. According to several contacts, the ACC presented the indictment to the Attorney General (AG), who buried it for two months before it was moved forward in the court.[58]

Corruption and rent-seeking are not the preserve of state-elites with global connections alone, however. It is important to understand corruption as a multi-scaled phenomenon and that the gateways to resources extend well beyond the confines of the internationally recognised capital city. Reflecting the findings of studies elsewhere in Africa,[59] ordinary health professionals will navigate the aid industry in order to secure the most lucrative returns available to them, often at the expense of the strength of the health system. It is reported, for example, that the issue of low salaries encourages health workers to seek informal increments to their wages, such as by charging patients illicit fees. This can undermine new initiatives. As part of the new FHCI project to offer basic health services without charges, President Ernest Bai Koroma announced plans to tackle this issue directly, declaring that: 'Our doctors and nurses have been underpaid and overworked. As a consequence, it became a common practice for health workers to charge vulnerable patients inappropriately to make up for their inadequate salaries'.[60] Nonetheless, the FHCI was severely undermined by the persistence of rent-seeking by health practitioners, who continued to supplement their meagre salaries through the illegal sale of medicines and health services that were now supposed to be free.[61]

Indeed, bureaucratic positions within the health sector offer health administrators a gatekeeping role through their control over access to resources and opportunities. This can provoke a range of corrupt, rent-seeking behaviour, including the creation of long lists of 'phantom workers' connected to the gatekeeper who claim salaries but who do not actually work in the health sector. In other cases we can see the manipulation of resource flows, such as the hiring of sub-contractors personally connected to health administrators for work in the health sector who subsequently over charge for the work or fail to complete it.[62] While donors often threaten to withdraw funding in the face of this rent-seeking, it is extremely

difficult to hold those responsible to account. For example, in 2012, the Gavi cash-based support was suspended after an external audit of the HSS programme. The MoHS was required to reimburse half a million USD of misused funds including for undocumented expenditure for trainings and workshops, overcharging for procurements (with three ambulances purchased for 80 percent higher than justifiable), and, the misappropriation of at least 14 motorcycles intended for peripheral health units.[63] Funding from Gavi and DfID was subsequently suspended and was only resumed once the 'Billiongate' trial of the 29 public officials implicated in the misuse of the health systems funds commenced in March 2013. Ultimately, however, the trial illustrated the toothless nature of anti-corruption reforms and the capacity of political elites to resist pressures for greater accountability. Of the 29 accused, only two physicians were convicted in the High Court. Crucially, the key public officials were acquitted, including the Chief Medical Officer, the Director of Primary Health Care, the Programme Manager Productive Health, the Director of Human Resources and Nurses Services, and the Permanent Secretary of the MoHS.[64] This was in spite of indirect evidence of large houses and expensive cars that were not consistent with official salaries, as well as kickbacks from suppliers.[65]

In summary, the acute dependence on external funding in the health sector undermines the state control over its health policy and the multiplicity of donor agendas has generated the growth of a complex array of parallel health systems. Meanwhile, the volume of resources, combined with lack of accountability in the health sector provides rent-seeking opportunities for gatekeepers in positions of authority, which has exacerbated the weakness of the health system. These two trends have important consequences for containing the EVD epidemic.

Ebola and strategies of extraversion

When international attention focused on EVD – particularly with the fear of the threat it posed to the West – an influx of resources into the health sector followed, providing lucrative opportunities for rent-seeking and corruption. The government of Sierra Leone spent over Le84 billion (20.7 million USD) in response to the outbreak and appealed to donors for support. The European Union duly pledged over 1 billion EUR from March until November 2014, the European Commission provided over 350 million EUR for humanitarian, development and research funds,[66] the UK 205 million GBP[67] and the Gates Foundation provided 50 million USD. The government established the National Ebola Response Centre (NERC) and a Health Emergency Account for all donations and appropriations to finance the response.[68]

The regular 'Ebola Outbreak Updates' on the MoHS website and Facebook page (established in April 2014) was designed to offer greater transparency to a distrustful population but also to make direct appeals to external donors. Over time this included the 'important note' at the end of the update with the Emergency Account Details and an appeal for direct cash transfers from those willing to help. Similarly, appeals were made from other sections of society for increased resources from outside. The Sierra Leone Telegraph, for example, directly appealed to global philanthropy in a piece entitled 'Ebola strikes first female doctor in Sierra Leone – appeal to Bill Gates for help':

> Please Mr. Bill Gates and Mrs Miranda Gates *[sic]*, help our doctor, sister, mother, colleague and friend, help Sierra Leone. We need 300,000 Euros to fly Dr. Buck out of Sierra Leone and to pay for her treatment in Hamburg![69]

It has been widely reported that large proportions of the funding to combat EVD has been siphoned off and misappropriated by a range of actors.[70] The government's auditors concede that 'Monies that have been set aside for the purpose of combating the Ebola outbreak may

have been used for unintended purposes, thereby slowing the government's response to eradicate the virus.'[71] Throughout the epidemic the government has encountered problems with 'ghost workers' on its Ebola staff payrolls, with some people forging identities or claiming for payments twice. A government spokesperson complains that 'the issue of ghost workers has been disingenuous on the part of some Sierra Leoneans who think this is time to make money when we are in a crisis.'[72] The Guardian also reports that

> Residents, journalists and an official told the Guardian that trucks carrying food aid were sometimes parked outside quarantine cordons, which intended recipients couldn't cross. The food was then looted by those meant to be distributing it. Burial teams have repeatedly gone on strike over unpaid hazard allowances.[73]

Indeed, Transparency International highlight that the 'Systemic corruption in the health sector in West Africa hurt the response to the Ebola epidemic'.[74] An in-depth 'Report on the audit of the management of the Ebola funds' by Sierra Leone's Auditor General for May to October 2014 catalogues a series of issues with the way government money was spent, including: large payments and withdrawals of over Le14 billion (3.5 million USD) made from the Emergency Health Response and Miscellaneous Accounts 'without *any* supporting documents to substantiate the utilisation of such funds'; a 'complete disregard for the law' during the public procurement of contractors and service providers to help contain EVD, meaning that the price paid was often overly inflated and poorly accounted for; the duplication of payments to politicians for their work communicating to their constituents about EVD; illegitimate claims by police and armed forces for hazard payments from hospitals; Le26 billion (6.4 million USD) paid out for healthcare workers' 'incentives' that was not accounted for; poorly documented loans granted where 'concern' was expressed that these were being received by individuals and not the charities combating EVD; and the withholding of Le525 million (130,000 USD) tax payments by suppliers and contractors. Following the audit, the ACC commenced its investigations and identified 39 individuals that included high-profile public officials who are required to report to them in relation to the management of funds and associated issues.[75]

The opportunities generated by the surge in external resources being channelled into Sierra Leone's health sector during the EVD epidemic thus reflected what might be characterised as a windfall moment within the context of an extended, recurrent crisis of the gatekeeper state. Access to the gateway of resources was suddenly and dramatically widened and extended to a range of individuals who, as best they could, sought to 'do well' out of the crisis. This windfall event was particularly conducive to rent seeking behaviour because the rubric of crisis necessitated an urgency which over-stretched an already weak state capacity to enforce accountability. However, we should not crudely dismiss this as some sort of uniquely 'African' moral aberration. First, the vast majority of Sierra Leoneans who engaged in efforts to contain EVD did so with great courage and at considerable personal risk, with little or no prospect of material reward. Second, to understand rent-seeking behaviour we should focus on the political economy of 'everyday corruption' in Africa.[76] In a situation where poverty and inequalities are vast and opportunities scarce, rent-seeking can be an integral feature of livelihoods strategies and, as Harris notes, in Sierra Leone 'nepotism, diversion of resources and low levels of productivity can be explained by workers with moral communal obligations … to those they support and loyalties … to those who orchestrated their post in the first place.'[77]

Structural violence in a predatory state

The recurrent political crises exacerbates structural violence by reproducing a 'semi-permanent state of exclusion'[78] in Sierra Leone. Those able to successfully navigate patronage networks for their own benefit may benefit from it (albeit to varying degrees), while those excluded from access to resources have severely diminished opportunities (particularly the youth, rural population and women). The EVD laid bare the violence and exclusionary nature of the country's gatekeeper politics, where it disproportionately impacted on certain segments of society it highlighted the existing social, economic and cultural patterns of exclusion.[79]

One aspect of this exclusion relates to gender. Women are a resource within neoliberal development: their unpaid labour mitigated the impact of Structural Adjustment and they become 'shock absorbers' in times of crisis.[80] In Sierra Leone, women's unpaid labour in the care economy fills the gaps the health system and women have taken on much of the burden of care in the EVD outbreak. This has direct implications for their risk of contracting EVD and yet, as Harman argues, women are 'conspicuously invisible' in much of the commentary on EVD, which obscures the multiple roles of women.[81]

Another is the entrenched rural-urban divide, which is crucial to understanding the state's failure to respond effectively to contain the initial outbreak. The rural-urban cleavages are rooted in the legacies of the government's "urban bias" policies that were intended to stimulate development but 'became a mechanism for the transfer of resources from rural peasants to the country's elite'.[82] These structural inequalities were exacerbated by external interventions: the rural poor were disproportionately disadvantaged by the introduction of user fees for health services because they pay disproportionately more for health care as compared to wealthier households in terms of the percentage of their incomes.[83] Even with the FHCI there were challenges in terms of accessing health care facilities in rural areas and, as we have already discussed, illicit costs for services that should be free. This has implications for containing EVD in rural areas. Farmer's observations during the outbreak reveals the dearth of health centres in rural areas.

> In Zwedru, we visited the Grand Gedeh's only hospital. Although there have been stories of doctors and nurses fleeing their posts, the fact is that many remain. But without personal protective equipment or other supplies, there isn't a lot they can do… In Ziah Town, a small village a couple of hours away, we met some community health workers… They were the front line in the struggle against Ebola, the ones who could bring information and services to the rural poor. But they were isolated and badly equipped.[84]

The real momentum to respond to the outbreak came with the shift in the infections from the East to the West of the country and the spread to urban areas. As Batty highlights, this laid bare deep mistrust between rural Sierra Leoneans and the Government, including the widely held assumptions that the response to the crisis was politically driven:

> Many wonder if the virus would have been approached differently if it had emerged in the northwest, where most of the senior [ruling party] APC officials, including the president, call "home." Indeed, only as the disease crossed from the southeast into other parts of the country did the crisis response intensify and the government finally enlist the help of the international community to help fight Ebola.[85]

Exclusion and isolation has engendered what the UNDP describes as a 'pervasive distrust of politics'[86] which had important consequences for the EVD epidemic.[87] Government messages telling people how to recognise and avoid the disease, to go to hospital for treatment and safe

burial practices were largely ignored by the local populations. There were also reportedly fears among the local population that the government and aid agencies are intentionally spreading the virus and that the government wanted to sell patients' blood or use limbs for rituals, which prompted a lack of cooperation with medical teams.[88] There were also public perceptions of corruption surrounding EVD and conspiracy theories circulating that the virus was a government ruse to bring in donations[89] or that so-called 'eastbola' was a strategy to depopulate the East of the country, which is the power-base of the opposition.[90] Lind and Ndebe reflect that the EVD epidemic has thus 'unmasked persisting deep public suspicion and mistrust of the state, laying bare the limits of post-conflict reconstruction to transform state-society relations'. They argue that the response has exacerbated social exclusion because 'quarantines, aggressive policing, closed borders and other restrictions on people's movements, hark back to military controls deployed during the region's long wars, thereby further eroding trust and confidence in public authorities.'[91]

Despite the civil war ending, Sierra Leone is not at peace in the broadest sense. Structural violence shift our gaze to the 'everyday violence' of the enduring, lived reality of 'small wars and invisible genocides' that are a normalised feature of post-war West Africa.[92] Ultimately, the EVD epidemic was not simply a medical crisis, but an infection that spread along the fault lines of the injustice generated by recurring political crises and deeply rooted structural violence.

Conclusion: a way forward?

Now that the immediate task of containing the virus has almost been achieved, the EVD epidemic is argued to constitute an 'opportunity' for a serious rethink of how global health risks can be dealt with more effectively in future. On the one hand, UK Prime Minister David Cameron worked with US President Barrack Obama to table a resolution to the WHO which called for the formation of a 'global health emergency workforce' that could respond to future epidemics and which would be 'composed of comprehensive emergency medical response teams that can be deployed effectively and quickly with adequate resources'. The WHO Secretariat subsequently proposed this initiative as part of a wider reconfiguration of the international communities' capacity to intervene in health emergencies.[93] On the other hand, it is recognised that building resilient health systems requires much more than material resources. The WHO recognises in its rethinking of the 'key principles' of building health system resilience in the aftermath of the EVD outbreak that this includes: the coordination of development partners' work; building each country's core capacities to 'detect, report and respond to public health emergencies'; enhancing 'community trust, engagement and ownership'; and to reduce the financial costs of accessing health services. The report also called for more 'predictable' financial support for health systems that should not affect the country's debt burdens.[94]

However, at its core, the prevailing emphasis on building health system 'resilience' as a means of facilitating the effective containment of future epidemics reflects a fundamental shortcoming in both the *political understanding* and *political ambition* needed to build stronger, inclusive health systems. It is not simply the case that the main actors are unaware of these political dynamics, and it is likely that there are political reasons that they have to focus on the technical 'resilience-building' approach. Since the end of the civil war we can witness a hybrid form of liberal peace-building in Sierra Leone informed to a large extent by an emerging mentality of 'make do and mend' among donors. The emphasis is placed on the need to reign in liberal expectations and settle for 'good enough governance' or 'second best solutions.'[95] This involves the continued promotion of liberal institutions but also the belief that the success of this project is premised upon securing popular legitimacy for them, not least the 'buy-in' of local power brokers. In Sierra Leone, this includes the resurrection

illiberal institutions such as the chieftaincy which, paradoxically, has been a focal point of societal tension in Sierra Leone throughout its history but also commands a degree of popular legitimacy that liberal state institutions might not.[96] It has also meant an awkward embrace of the idea of working 'with the grain' of the logics of patron-client networks by identifying individuals in state authority who can be worked with to drive through change and directing authority and resources towards them, even if this does not preclude, and could even exacerbate, ongoing patronage politics. This hybrid liberal project offers little to challenge the structural inequity of the global system that entrenches the external dependency and enclave economic activity that contributes to the weakness of the state in the first place. Moreover, Harris notes that the tensions generated by this donor-driven hybrid approach are 'abundantly clear' and that elites have displayed remarkable dexterity in their capacity to adjust to the 'ever-evolving calculation' of how to balance external demands for reform with their political prerogative of maintain power through dispensing patronage.[97] Labonte argues that this reproduces social exclusion by leaving non-elites with little option other than to navigate 'between liberal and illiberal governance institutions to accrue the kinds of public goods, justice and/or other necessities they need to survive.'[98]

This structural violence generated by the patched-up post-war political status quo in Sierra Leone has a debilitating impact on the health system and is acutely highlighted by the EVD epidemic. A less ambitious project of building health systems 'resilience' around the status quo therefore does little to address the more fundamental structural transformation required to build more inclusive and socially just health systems in future. Such a project would require a much broader conversation about HSS and an ambition to address a range of interconnected issues, including: Sierra Leone's dependent position in the world economy and its reliance on mineral exports; the need for a sustained redistribution of global wealth to underpin an expansionary state programme for the sectors fundamental to the health system, in particular higher education and health infrastructure; measures to decrease the 'brain drain' of skilled medical staff by ending externally-promoted austerity measures that limit medical staff salaries; and ending user fees for medical services and medicines. This is by no means an exhaustive list. It nonetheless seeks to illuminate the kinds of wider conversations that would be needed to shift away from the emerging a agenda of building coping mechanisms and health systems 'resilience' towards a long-term, more ambitious agenda of HSS through tackling some of the great challenges posed by the recurrent crises of the gatekeeper state and the injustice it reproduces.

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[1] WHO, *Building resilient health systems*," 1.

[2] WHO, *Ebola Situation Reports*

[3] Refer to WHO, *World Health Statistics*; WHO "Sierra Leone: Statistical profile" and WHO Regional Office for Africa, "African Health Workforce Observatory."

[4] World Bank website http://data.worldbank.org/country/sierra-leone

[5] Enaemark, forthcoming.

[6] Gallagher, James. 'Ebola vaccine is "potential game-changer"' *BBC,* 31 July 2015. http://www.bbc.co.uk/news/health-33733711

[7] WHO, "Building resilient health systems," 1 (our italics).

[8] MSF "Ebola."

[9] Kieny, "Ebola and health systems"; Kim, "What Ebola Taught the World"; Cairns, "Ebola is Still Here", 2.

[10] Refer to Wilkinson and Leach, "Briefing"; Lind and Ndebe, "Return of the Rebel."

[11] See for example Lavelle, "Moving in from the periphery."

[12] Harman and Brown. "In from the margins?". 71. Refer also to Death, "Introduction", 1; Brown, "A question of agency"; and Chabal, and Daloz, *Africa Works*, 142.

[13] Cooper, *Africa Since 1940*, 157.
[14] Harris, *Sierra Leone*
[15] Galtung, "Violence, peace."
[16] Cooper, *Africa Since 1940*, 157.
[17] Beresford, "Power, patronage," 229.
[18] *Ibid*., 226.
[19] *Ibid*., Erdmann and Engel, "Neopatrimonialism reconsidered."
[20] Severino and Ray. *Africa's moment*.
[21] World Bank, *Global Economic Prospects*, 14.
[22] GoSL "*Agenda for prosperity*," xi; GoSL "*Agenda for change*," xx.
[23] World Bank, "*Country Assistance*," 1.
[24] Taylor, "Why Africa is not rising."
[25] Zack-Williams, "Sierra Leone," 22.
[25] IMF, *IMF Executive Board*.
[26] IMF *Sierra Leone: Staff report*, 4.
[27] IMF, *Sierra Leone Gets $102 Million*.
[28] *Ibid*.
[29] Kaldor with Vincent, *Evaluation*, 4
[30] Mkandawire, "Can Africa Turn from Recovery," 171.
[31] UNDP 'Human Development Report', 2-3
[32] Zack-Williams, "Sierra Leone."
[33] Bayart, "Africa in the World," 220.
[34] Bøås, "Liberia and Sierra Leone."
[35] Luke, "The Politics of Economic."
[36] Reno, *Corruption and State Politics*, 4.
[37] Fanthorpe, "On the Limits of Liberal Peace."
[38] Richards, *Fighting For the Rainforest*.
[39] *Ibid*.
[40] Harris, *Sierra Leone*.
[41] Bøås, "Liberia and Sierra Leone."
[42] Transparency International. *Corruption Perceptions Index.*
[43] For discussion see Fanthorpe, "On the Limits."
[44] Africa Health Observatory website
http://www.aho.afro.who.int/profiles_information/index.php/Sierra_Leone:Health_financing_system
[45] *Ibid*.
[46] Lee, "The Pit and the Pendulum."
[47] Labonte, "From patronage to peacebuilding?" 91.
[48] Gavi, "Sierra Leone," 4.
[49] 'British Aid Money To Sierra Leone Investigated After Claims Of Misuse.' *Huffington Post*, 15 April2013.
http://www.huffingtonpost.co.uk/2013/04/15/sierra-leone-aid-money_n_3083057.html
[50] GoSL, *NHSSP*, 14.
[51] GoSL, *Health Compact*, 4.
[52] Amnesty International, *At a crossroads*, 17.
[53] Brown "Sovereignty Matters," 262.
[54] Bayart, "Africa in the World."
[55] Ellis. *Season of Rains.*
[56] Benton, *HIV Exceptionalism.*
[57] ACC, "Monitoring Court Report."
[58] Wikileaks. "Minister of Health indicted."
[59] Kingsley, "NGOs, Doctors."
[60] Cited in Yates, *Insight*
[61] Nossiter, Adam. "Sierra Leone's Health Care System Becomes a Cautionary Tale for Donors." *The New York Times,* 13 April 2013. http://www.nytimes.com/2013/04/14/world/africa/sierra-leone-graft-charges-imperil-care-and-aid.html?pagewanted=all&_r=0
[62] Donnelly, "How did Sierra Leone," 1396
[63] GAVI Alliance, *Sierra Leone*, 5-6, 22.
[64] ACC, "News - ACC indicts"; ACC, "News - High Court acquits."
[65] Nossiter, "Sierra Leone's"
[66] EC, "Ebola response."

[67] Mark, Monica. 'Sierra Leone: Journalist arrested after questioning official Ebola response.'*The Guardian*, 5 November 2014 http://www.theguardian.com/world/2014/nov/05/ebola-journalist-arrested-over-criticism-sierra-leone-government-response
[68] Audit Service Sierra Leone, *Report on the Audit*.
[69] "Ebola strikes first female doctor in Sierra Leone." *Sierra Leone Telegraph*, 11 September 2014 http://www.thesierraleonetelegraph.com/?p=7352
[70] Hitchen, "Mismanagement of Sierra Leone's." In the press see for example: O'Carroll, Lisa. "Sierra Leone investigates alleged misuse of emergency Ebola funds." *The Guardian,* 17 February 2015. http://www.theguardian.com/world/2015/feb/17/sierra-leone-investigates-alleged-misuse-of-emergency-ebola-funds; O'Carroll, "A third of Sierra Leone's Ebola budget unaccounted for says report", *The Guardian,* 16 February 2015 http://www.theguardian.com/world/2015/feb/16/ebola-sierra-leone-budget-report; BBC, "Sierra Leone audit." "Sierra Leone audit claims Ebola funds unaccounted for", *BBC*, 13 February 2015 http://www.bbc.co.uk/news/world-africa-31461564
[71] Audit Service Sierra Leone, *Report on the audit*, 6.
[72] Farge, Emma. "Sierra Leone to prosecute fraudulent Ebola 'ghostworkers', *Reuters*, 10 February 2015 http://www.reuters.com/article/2015/02/10/us-health-ebola-fraud-idUSKBN0LE2M920150210
[73] Mark, "Sierra Leone."
[74] Transparency International, "Ebola."
[75] ACC, "Public notice" i.
[76] Blundo and De Sardan. "Everyday Corruption."
[77] Harris, Sierra Leone, 156
[78] Bøås, "Liberia and Sierra Leone," 697-8; Beresford, "Power, patronage," 226.
[79] Baylies, "Cultural hazards," 71; Anderson, *Gender, Risk*. On Ebola see Diggins and Mills, "The Pathology."
[80] Moser, "Gender planning."
[81] Harman, "Ebola, Gender".
[82] Riddell, "Sierra Leone," 118.
[83] Fabricant *et al.,* "Why the poor."
[84] Farmer, "Diary."
[85] Batty, "Reinventing 'Others."
[86] Kaldor with Vincent, *Evaluation*, 4.
[87] Oxfam, "Mistrust and confusion".
[88] "Ebola in west Africa: Death and disbelievers", *The Economist,* 2 August 2014 http://www.economist.com/news/middle-east-and-africa/21610250-many-sierra-leoneans-refuse-take-advice-medical-experts-ebola-death
[89] Wilkinson and Leach, "Briefing," 9.
[90] Economist, "Ebola"; Batty, "Reinventing 'Others."
[91] Lind and Ndebe, "Return," 3.
[92] Scheper-Hughes, *Death Without Weeping*.
[93] WHO, *Ensuring WHO's Capacity*.
[94] WHO, *Building Resilient Health Systems*, 2.
[95] Harris, Sierra Leone, 157
[96] Fanthorpe, "On the Limits."
[97] See Harris, *Sierra Leone,* 156
[98] Labonte, "From patronage to peacebuilding?" 114-5.

Bibliography

Amnesty International. *At a Crossroads: Sierra Leone's Free Health Care Policy*. London: Amnesty International, September 2011. https://www.amnestyusa.org/sites/default/files/pdfs/sierral_maternaltrpt_0.pdf

Anderson, Emma.-Louise. *Gender, Risk and HIV: Navigating Structural Violence.* Basingstoke: Palgrave Macmillan, 2015.

Anti-Corruption Commission (ACC). "Public notice in respect of Ebola funds." Freetown: ACC, 17 February 2015. http://www.anticorruption.gov.sl/show_news.php?id=462#sthash.zIr788IW.dpuf

ACC, "Monitoring Court Report 31st March-1st April, 2015", Freetown: ACC, April 2015. http://www.anticorruption.gov.sl/index.php?p=102&pn=Concluded%20Criminal%20Cases

ACC. "News - High Court acquits Dr Kizito Daoh and four others of corruption offences." Freetown: ACC, 28 October 2013. http://www.anticorruption.gov.sl/show_news.php?id=271

ACC. "News - ACC indicts 7 medical practitioners and 22 others for various offences relating to the misuse of Gavi funds and the 2011 audit service report findings", Freetown: ACC, 07 March 2013. http://www.anticorruption.gov.sl/show_news.php?id=188;
Audit Service Sierra Leone. "Report on the audit of the management of the Ebola funds - May to October 2014." Freetown: ASSL, 31 October 2014. https://afrosai-e.org.za/sites/afrosai-e.org.za/files/report-files/assl-report-on-ebola-funds-management-may-oct-2014.pdf
Batty, Fodei. "Reinventing 'Others' in a Time of Ebola." *Cultural Anthropology: Ebola in Perspective,* 07 October 2014 http://www.culanth.org/fieldsights/589-reinventing-others-in-a-time-of-ebola
Bayart, Jean-François. "Africa in the World." *African Affairs*, vol. 99, no.395 (2000): 217-267. doi:10.1093/afraf/99.395.183
Baylies, Carolyn. "Cultural hazards facing young people in the era of HIV/AIDS", in *The Political Economy of AIDS in Africa*, edited by Alan Whiteside and Nana Poku, 71-84. Aldershot: Ashgate, 2004.
Benton, Adia. *HIV Exceptionalism: Development through Disease in Sierra Leone*. Minneapolis, MN: University of Minnesota Press. 2015.
Beresford, Alexander. "Power, patronage and gatekeeper politics in South Africa." *African Affairs*, 114, no.455 (2015): 226-248, 229. doi: 10.1093/afraf/adu083
Blundo, Giorgio and Olvier De Sardan. *Everyday Corruption and the State in Africa.* London: Zed Books, 2006
Bøås, Morten. "Liberia and Sierra Leone— dead ringers?" *Third World Quarterly* 22, no.5 (2001): 697–723. doi:10.1080/01436590120084566
Brown, William. "A question of agency." *Third World Quarterly* 33, no.10 (2012): 1889-1908. doi:10.1080/01436597.2012.728322
Brown, William. "Sovereignty Matters: Africa, Donors and the Aid Relationship." *African Affairs* 112, no.447 (2013): 262-282. doi: 10.1093/afraf/adt001
Cairns, Edmund. *Ebola is Still Here*. Oxford: Oxfam International, 27 February 2015. http://policy-practice.oxfam.org.uk/publications/ebola-is-still-here-voices-from-liberia-and-sierra-leone-on-response-and-recove-345644?cid=em_LKET_0215;
Chabal, Patrick, and Jean-Pascal Daloz. *Africa Works*. Bloomington: Indiana University Press, 1999.
Cooper, Frederick. *Africa Since 1940: The past of the present*. Cambridge: Cambridge University Press, 2002.
Death, Carl. "Introduction: Africa's International Relations." *African Affairs* adv041 (2015): 1-6. doi:10.1093/afraf/adv041
Donnelly, John. "How did Sierra Leone provide free health care?" *The Lancet* 377, no.9775 (2011): 1393-1396. doi:10.1016/S0140-6736(11)60559-X
Ellis, Stephen. *Season of Rains: Africa in the World*. Chicago: University of Chicago Press. 2011
Enamark, Christian. Forthcoming, TWQ special issue.
Erdmann, Gero, and Ulf Engel. "Neopatrimonialism reconsidered." *Commonwealth and Comparative Politics* 45, no.1 (2007): 95-119. doi:10.1080/14662040601135813
European Commission. "Ebola response: EU scales up aid with planes, material aid and research support." Brussels: EC, 06 November 2014 http://europa.eu/rapid/press-release_IP-14-1462_en.htm
Fabricant, Stephen. J., Clifford W. Kamara and Anne Mills. "Why the poor pay more: household curative expenditures in rural Sierra Leone." *International. Journal of Health Planning and Management*, 14 (1999): 179–199. doi:10.1002/(SICI)1099-1751(199907/09)
Fanthorpe, Richard. 'On the Limits of Liberal Peace' *African Affairs* 105, no.418: 27-49. doi:10.1093/afraf/adi091
Farmer, Paul. 'Diary', *London Review of Books,* 36, no.23, 23 October 2014: 38-39. http://www.lrb.co.uk/v36/n20/paul-farmer/diary
Galtung, Johan. "Violence, peace, and peace research." *Journal of Peace Research* 6, 3 (1969): 167-191. Doi: 10.1177/002234336900600301
GAVI Alliance. *Sierra Leone- Audit of Health Systems Strengthening (HSS) Support Disbursed in the period 2008-2010.* Geneva: GAVI Secretariat, 03 April 2013. http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCEQFjAA&url=http%3A%2F%2Fwww.gavi.org%2Flibrary%2Fgavi-documents%2Flegal%2Faudit-report--sierra-leone---april-2013%2F&ei=vg1iVPDuNpXasASp1IDgBQ&usg=AFQjCNGfG8s62qlHIdQ2vjU0jkJtQ8VQvw&sig2=r3YQ7lnq-Jj02KnSTzgfIA&bvm=bv.79189006,d.cWc
Government of Sierra Leone. *Agenda for Change (2008-2012)*. Freetown: GoSL. http://unipsil.unmissions.org/portals/unipsil/media/publications/agenda_for_change.pdf
Government of Sierra Leone. *Agenda for Prosperity: The Road to Middle Income Status (2013-2018).* Freetown: GoSL. http://www.sierra-leone.org/Agenda%204%20Prosperity.pdf

Government of Sierra Leone. *Health Compact*. Freetown: GoSL, December 2011. http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Sierra_Leone/Government%20of%20S.%20Leone%20Health%20Compact.pdf
Government of Sierra Leone. *National Health Sector Strategic Plan (NHSSP) – 2010-2015*. Freetown: GoSL, November 2009. http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Sierra_Leone/NationalHealthSectorStrategicPlan_2010-15.pdf
Hanlon, Joseph. "Is the international community helping to recreate the preconditions for war in Sierra Leone?" *The Round Table* 94, no. 381 (2005): 459-472. doi:10.1080/00358530500243641
Harman, Sophie, "Ebola, Gender, and Conspicuously Invisible Women in Global Health Governance." TWQ, forthcoming.
Harman, Sophie, and William Brown. 'In from the margins?'. *International Affairs* 89, no.1 (2013): 69-87. doi: 10.1111/1468-2346.12005
Harris, David. *Sierra Leone*. Oxford: Oxford University Press, 2014.
Hitchen, Jamie. "Mismanagement of Sierra Leone's Ebola spending." London: ARI, 20 Feb 2015. http://www.africaresearchinstitute.org/blog/mismanagement-ebola-spending/;
Huff, Amber. "Ebola and Lessons for Development." *IDS Practice Paper in Brief* 16, 1 (2015). http://opendocs.ids.ac.uk/opendocs/bitstream/123456789/5849/1/ID557%20Online.pdf
International Monetary Fund (IMF). "Sierra Leone Gets $102 Million in Extra IMF Financing, Debt Relief." *IMF Survey Magazine: Countries & Regions*, 24 March 2015 http://www.imf.org/external/pubs/ft/survey/so/2015/car030315a.htm
IMF. *Sierra Leone: Staff report for the 2013 article iv consultation and request for a three-year arrangement under the extended credit facility—debt sustainability analysis'*, 18 October 2013. https://www.imf.org/external/pubs/ft/dsa/pdf/2013/dsacr13330.pdf
IMF. *IMF Executive Board Concludes the 2013 Article IV Consultation with Sierra Leone*. 24 November 2013. http://www.imf.org/external/np/sec/pr/2013/pr13450.htm
Kaldor, Mary with James Vincent. *Evaluation of UNDP assistance to conflict-affected countries: Case study Sierra Leone*. New York: UNDP, 2006. http://web.undp.org/evaluation/documents/thematic/conflict/SierraLeone.pdf
Kieny, Marie-Paule. "Ebola and health systems." Geneva: WHO, 12 December 2014. http://www.who.int/mediacentre/commentaries/health-systems-ebola/en/;
Kim, Jim Yong. "What Ebola Taught the World One Year Later." *Time,* March 24, 2015. http://time.com/3755178/ebola-lessons/?xid=emailshare#3755178/ebola-lessons/. Refer also to
Kingsley, Pete. "NGOs, doctors, and the patrimonial state–tactics for political engagement in Nigeria." *Critical African Studies* 6, no.1 (2014): 6-21. doi:10.1080/21681392.2013.852029
Labonte, Melissa T. "From patronage to peacebuilding?" *African Affairs* 111, no.442 (2012): 90-115. doi: 10.1093/afraf/adr073
Lavelle, Kathryn. "Moving in from the periphery: Africa and the study of international political economy." *Review of International Political Economy,* 12: 2, May (2005): 364–79. doi:10.1080/09692290500105946
Lee, Kelley. "The Pit and the Pendulum", *Development* 47, no.2 (2004): 11-17. doi:10.1057/palgrave.development.1100025
Lind, Jeremy and Johnny Ndebe, 'Return of the Rebel', *Practice Paper in Brief* 19 (2015). http://opendocs.ids.ac.uk/opendocs/bitstream/123456789/5852/1/ID560%20Online.pdf
Luke, David Fasthole. "The Politics of Economic Decline in Sierra Leone." *Journal of Modern African Studies.* 27, 1 (1989): 133-14. doi: 10.1017/S0022278X00015676
Medicins Sans Frontieres (MSF) "Ebola: We must finish the job", London: MSF, 7 July 2015 http://www.msf.org.uk/article/ebola-we-must-finish-the-job
Mkandawire, Thandika. "Can Africa Turn from Recovery to Development?" C*urrent History*, May (2014): 171-177 http://www.currenthistory.com/Article.php?ID=1153
Moser, Caroline O. "Gender planning in the Third World." *World Development* 17, no.11 (1989): 1799-1825. doi:10.1016/0305-750X(89)90201-5
Oxfam International. "Mistrust and confusion are allowing Ebola to thrive", Oxford: Oxfam International 27 October 2014. https://www.oxfam.org/en/pressroom/pressreleases/2014-10-27/mistrust-and-confusion-are-allowing-ebola-thrive-west-africa
Reno, William. *Corruption and State Politics in Sierra Leone*. Cambridge: Cambridge University Press, 1995.
Richards, Paul. *Fighting for the Rainforest: War, Youth and Resources in Sierra Leone.* Oxford: James Currey, 1996.

Riddell, Barry. "Sierra Leone: Urban-elite bias, atrocity & debt." *ROAPE* 32, no. 103 (2005): 115-133. 10.1080/03056240500121032
Scheper-Hughes, Nancy. *Death Without Weeping*. University of California Press, 1993.
Severino, Jean-Michel, and Olivier Ray. *Africa's Moment*. Cambridge: Polity Press, 2011.
Taylor, Ian. "Why Africa is not Rising". *Review of African Political Economy*. Forthcoming.
Transparency International, "Ebola: corruption and aid", Berlin: Transparency International, 27 February 2015. http://www.transparency.org/news/feature/ebola_corruption_and_aid
Transparency International. *Corruption Perceptions Index*. Berlin: Transparency International, 2014 https://www.transparency.org/country#SLE
UNDP. *Human Development Report - The Rise of the South*. UN: Geneva, 2013 http://www.gm.undp.org/content/dam/undp/library/corporate/HDR/2013GlobalHDR/English/HDR2013%20Report%20English.pdf
WHO. *Building resilient health systems in Ebola-affected countries*, Geneva: WHO, 9 January 2015 http://apps.who.int/gb/ebwha/pdf_files/EBSS3/EBSS3_INF2-en.pdf
WHO. *Ensuring WHO's capacity to prepare for and respond to future large-scale and sustained outbreaks and emergencies.* Geneva: WHO, 9 January 2015. http://apps.who.int/gb/ebwha/pdf_files/EBSS3/EBSS3_3-en.pdf
WHO. "Sierra Leone: WHO Statistical Profile." http://www.who.int/gho/countries/sle.pdf?ua=1
WHO, *Ebola Situation Reports – Archive*, September 9th 2015. http://apps.who.int/ebola/ebola-situation-reports-archive
WHO, *World Health Statistics*, Geneva: WHO, 2013. http://www.who.int/gho/publications/world_health_statistics/EN_WHS2013_Full.pdf
WHO Regional Office for Africa. "African Health Workforce Observatory HRH fact sheet Sierra Leone", Brazzaville: WHO, 2006. http://www.hrh-observatory.afro.who.int/en/country-monitoring/87-sierra-leone.html
World Bank. *International Development Association International Finance Corporation and Multilateral Investment Guarantee Agency Country Assistance Strategy Progress Report for the Republic Of Sierra Leone*, Washington: World Bank, July 12, 2012. http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2012/07/23/000333037_20120723002431/Rendered/INDEX/699130CASP0P130Official0Use0only090.txt
World Bank. *Global Economic Prospects: Sub-Saharan Africa*, June 2015. http://www.worldbank.org/content/dam/Worldbank/GEP/GEP2015b/Global-Economic-Prospects-June-2015-Sub-Saharan-Africa-analysis.pdf
Wikileaks. "Minister of Health indicted on corruption charges." 4 November 2009:17:20. https://www.wikileaks.org/plusd/cables/09FREETOWN435_a.htm [Accessed 11/06/2015]
Wilkinson, Annie, and Melissa Leach. "Briefing: Ebola–myths, realities, and structural violence." *African Affairs* (2014): adu080. doi:10.1093/afraf/adu080
Yates, Rob. *Insight on Free Health Care Launch in Sierra Leone*, DFID Human Development Resource Centre: London, April 2010 http://hdrc.dfid.gov.uk/wp-content/uploads/2012/09/272216_LR-Scoping-Mission-_CPHF__Report-Sierra-Leone.pdf
Zack-Williams, Alfred B. "Sierra Leone: the political economy of civil war 1991-98." *Third World Quarterly* 20, no. 1 (1999): 143-162. doi:10.1080/01436599913965