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AN ASSESSMENT OF THE ROLE OF WORLD HEALTH ORGANISATION (WHO) IN GLOBAL HEALTH GOVERNANCE: A CASE ON THE EBOLA AND COVID-19 OUTBREAK IN SIERRA LEONE

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Abstract:
This study investigates the role of the World Health Organisation (WHO) in global health governance with a case study on the Ebola and Covid-19 outbreak in Sierra Leone. Two specific sampling techniques were used to get respondents from whom information was elicited: simple random and purposive. A total of seventy (70) respondents, including medical doctors, nurses, civil societies, WHO representatives, health experts, and ordinary Sierra Leoneans, are aware of health issues. Ebola and COVID-19 are challenges in Africa and have caused health issues and adverse effects on the global health problem. The result reveals the need that has been identified and, however, made it clear that the responsibility to ensure the right to health for all lies not only with states as their obligations to their own people as required by their national constitutions and the principles of sovereignty among other policies but also with the international community as a critical partner considering the implications of health issues such as infectious

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diseases may have in a global village. Among many other impacts of the decade conflict was the devastating effect on the health sector. On the one hand, the war did not only stop at destroying health facilities that had already been prepared but also had to force health workers in their search for a safe heaven to flee these villages in their aggressive search for big towns and could not return any longer knowing the implications of their decision to go back in terms of service delivery and other socio-economic opportunities they face in these big cities. However, committed medical doctors had to flee the country to other places in America and Europe. Some did so because of the deplorable condition of the health sector, and others because of security. Even after the war, the majority of these doctors who left could not come back, even those who had left on grounds of scholarship. The MoHS is expected to provide leadership and coordinate the efforts of all healthcare providers and financiers at all levels, irrespective of their level of involvement. Yet, the MoHS is left with no option but to commit the few qualified and competent medical doctors to the issues of citizens' health. It was evident that succeeding governments could not prioritise health issues in the reconstruction process. In the middle of this deplorable health situation came the outbreak in 2014 that, within a short period, negatively impacted the health systems in all three countries (Sierra Leone, Liberia, and Guinea). Many Sierra Leoneans expected an immediate intervention by the international community on the basis that the immediate involvement with a more responsive and holistic approach by the international community through global health governance initiatives would have stopped the spread at an initial stage. Nevertheless, this was not the case, rather it was only after the death toll rose to a certain amount and other nationals contracted the disease it became a matter of global concern, thereby promoting the late response that was made. The aim of examining the structures put in place by WHO in its global health governance initiative is not only to end the spread of the virus but also to prevent future outbreaks, assessing the impact created by such a structure during the Ebola outbreak in Sierra Leone; highlighting the challenges faced by WHO in its initiative in ending the outbreak and preventing its spread to other countries considering the obligation owes by the international community in protecting other states from such life-threatening epidemics and finally suggesting ways that will further improve WHO in its Global health governance and its intervention into the health crisis of states in cases of outbreaks like the Ebola Virus Disease but the late response by Global Health Partners also causes the emergence and high effect of Covid-19 in Sierra Leone.

JEL: I18, F53, H51, O15, J18, N47, P16

Keywords: Covid-19, Ebola, WHO, global health, governance, response, MoHS

1. Introduction

Freetown, SierraLeone - June 15: Vaccination against Covid-19 at Princess Christian Hospital in Africa on June 15, 2021 Freetown

Makeni, Sierra Leone - August 26, Ebola Burial Team on August 26, 2014

The World Health Organization (WHO) is the leading international organisations responsible for global public health. As the coordinator of the global health architecture, the WHO plays a crucial role in shaping and implementing policies and strategies and is responsible for major health emergencies worldwide.

The solution lies not in turning one back on globalisation, but in learning how to manage it. In other words, there is a crying need for better global governance.

Until the 1990s, it was believed that nation-states and multilateral organisations with state members were the only actors on matters regarding international health. This was seen evident in the way and manner, matters relating to health were arranged. Based on critical observations made, health funding was mainly bilateral, with agreements and other relative matters flowing between donor and recipient governments only. When it was time to eradicate diseases, it was considered solely the responsibility of national ministries, even though there were signs of involvement made by the World Health Organization (WHO). Such interventions would, however, be mere coordination by WHO with few sets of partners. It goes without saying that the system was not well coordinated and robust enough to be able to adequately handle issues of global health. The reporting system provided was guided by International Health Regulations, and this was to report outbreaks. Thus, this system was referred to as "the Multilateral Health regime". Actors who played key roles were very small with responsibilities clearly spelt out. It was evident that throughout such a system, it could be ascertained that only the interests of powerful Western states were met, so developing countries were not an issue worth critical consideration. In cases where there is a rapid, globalised spread of emerging and re-emerging infectious diseases, these powerful states were not too disturbed as it happens in the present time. They always felt secure with their advanced medical and administrative capacities and, therefore, could adequately prevent and control outbreaks and defend borders from diseases on their own and did not rely on the IHR to handle outbreaks.

Globalisation has taken the lead in every sphere, along with increasing economic interdependence and migration of people. The movement of goods and services could also be seen as another key factor why the issue of international health was seen as necessary to reconstruct and handle. Global Health Governance (GHG) was seen as pivotal with the strong conviction that infectious diseases emerging or re-emerging somewhere can have repercussions everywhere if not adequately handled and catered for. This notion, among others, however, gave new urgency to addressing health on a global scale.

The concept of Global Health Governance has been seen as one very complex, with a plethora of new actors and the accompanying surge of uncoordinated activities. It became obvious that the involvement of these new actors has brought new resources and ideas. Networking has been seen as paramount, and partnership is key to enhancing global health.

Glaringly noticed in contemporary governance are the dynamics in health risks and opportunities which have raised questions as to the complacency that has been shown by developed countries. It is now clear that the capacity to influence health determinants, status and outcomes cannot be assured through national actions alone because of the intensification of cross-border and trans-border flows of people, goods and services, and ideas. Hence the need for effective assessment with collaboration by governments, businesses and civil societies has been seen as crucial to efficiently handle the numerous risks going along with health-related matters. Enabling a formidable governance system has attracted debates and discourses around such issues, which have led the international community to re-examine existing rules and responsible institutions that have been shaping health-related policies and practices not only at the sub-national level but also at national, regional and global level.

Richard (2002) has observed that there are a series of health determinants affected by factors outside the health sector. Among these outside factors are trade and investment flow, collective violence and conflict, illicit and criminal activities, environmental change, and communication technologies. Based on these abnormalities, it has become apparent that there is an urgent need to broaden the public health agenda to a certain extent that it takes account of these globalizing forces and also ensures that the protection and promotion of human health are placed higher on other policy agendas. Thus, it proves beyond all reasonable doubt that the current system of international health governance (IHG) has loopholes and, therefore, will not be able to adequately handle the increasing needs surrounding health and its governance. A big gap has been noticed in this process, which requires attention. Therefore, according to many, the only solution is reformation through the introduction of a global health governance (GHG) system.

Since the adoption of the MDGs and efforts made to comply with the target set in these goals, based on observations from most countries around the world, there is still no assurance of a reduction in child mortality and also containment of the spread of HIV/AIDS. It is obvious that the international community has not achieved fundamental

improvements in global health by significantly reducing health inequalities, among others. It has been considered a shame but also a painful fact that the MDGs have woefully failed to adequately and effectively meet the challenges of fundamental human needs. Today, the world has again embraced the Sustainable Development Goals (SDGs) as its main aspiration.

The arena of international relations has undergone significant changes in the last two decades with respect to tackling issues of health governance. As a matter of fact, the international system is now comprised of multiple players with different amendments and reformations in which emerging economies are playing increasingly central roles. The essence of this new development has been identifying more sustainable ways that will improve the governance system. As part of its drive, the WHO has new platforms for international diplomacy on issues of health that are also gaining new importance. These opportunities, according to Kickbusch (2010), will be used as additional opportunities to position agendas and set new priorities. However, this new trajectory is seen as relevant, as she mentions:

> "*Our understanding of health" itself, its determinants, and how we address it as a policy issue has also changed. This is the result of changing lifestyles and demographic and epidemiological transitions that are being experienced as populations' age and countries advance in social and economic development. New global challenges resulting from industrial growth, globalization and increasing interdependence, such as climate change, food insecurity, epidemic levels of chronic diseases and pandemic disease, impact on human health and wellbeing and must be addressed in public policy*."

The belief many have been that, as the determinants of health increasingly stem from collective problems that, according to several studies conducted cannot be adequately addressed by the Westphalia model of independent nation-states despite the numerous strategies that have been put in place, it has however become a clear fact that national governments as a matter of urgency, must increasingly look to the multilateral system for solutions which could be provided by global health governance.

Sierra Leone, as an independent state, has experienced a brutal civil war which engulfed the country for over a decade. Among many other impacts of this bloody war was its devastating effect on the health sector. The effect the war had on Sierra Leone's health sector was twofold when critically examined. On the one hand, the war did not only stop at destroying health facilities that had already been prepared but also had to force health workers in their search for a safer haven to flee these villages for big towns and could not return any longer knowing the benefits they would miss should they revert to these villages where they once lived. On the other hand, committed medical doctors had to flee the country to other places in America and Europe. Some did because of the deplorable condition of the health sector and others because of security. Even after the war, the majority of these doctors who left could not come back, even those who had left

on the grounds of scholarship. It was also evident that succeeding governments could not prioritize health issues in the reconstruction process.

Governing health issues in Sierra Leone is the primary responsibility of the Ministry of Health and Sanitation, which has, among other things, the aim of ensuring effective service delivery through a prepared National Health Sectors Strategic Plan (NHSSP) serving as the road map for the said sector. According to this plan, "*Governance in health addresses the actors involved in governing the health sector (MoHS) [Ministry of Health and Sanitation] and stakeholders), what needs to be governed and, to a limited extent, how it will be done*."[ii] From this plan, it could be discovered that numerous responsibilities have been conferred on the MoHS. Key among these responsibilities have been the following: formulating policy, setting standards and regulations, collaborating and building coalitions, and monitoring and overseeing resource mobilization. The MoHS is expected to provide leadership and coordinate the efforts of all healthcare providers and financiers at all levels, irrespective of their level of involvement. This enhanced role, as laid down by the plan, requires the MoHS to develop, as part of its core activities, the capacity of staff at both the local and national levels, which will play a pivotal role in devolving processes that have been going on since 2008.

It is worth mentioning the fact that irrespective of how innovative the strategic plan is, its successful implementation largely depends on budgetary allocations that will enhance its core activities without hindrance. In addition to this has also been the relevance of trained and qualified personnel, logistical support and, most importantly, effective and efficient governance structures. It has been observed with dismay that the devolution process has not yielded any dividend as only responsibilities were devolved. However, such were not devolved with the adequate resources needed for effective service delivery. Thus, personnel have not been adequate, logistical support has not been enough, and even medical supplies have been coupled with inadequate budgetary allocation. This, therefore, limited the ministry from meeting the demands of the general public and its core mandates through the effective delivery of health care services to all citizens.

The Ebola and COVID-19 outbreaks have highlighted the critical need for strong global health governance to effectively respond to public health emergencies. As a leading international health organization, the World Health Organization (WHO) has a pivotal role to play in strengthening global health systems and coordinating pandemic response efforts. This research outlines key recommendations for the WHO to enhance global health governance in Sierra Leone, focusing on the Ebola and COVID-19 crises. The outbreaks of Ebola and COVID-19 in Sierra Leone had significant impacts on the perceptions and experiences of the local population (2014-2016).

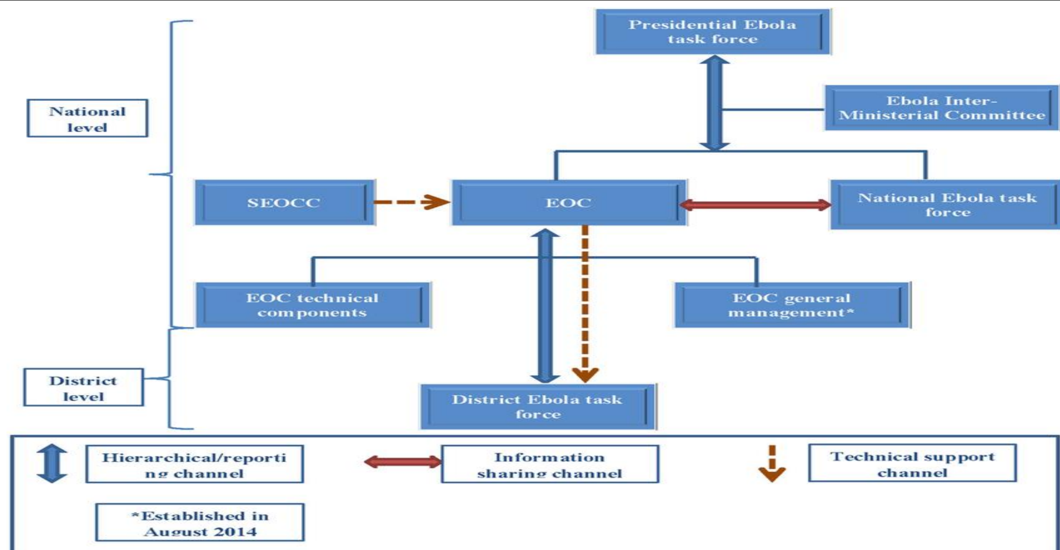
[ii] Maureen Quinn (2016) Governance and Health in Post-Conflict Countries: The Ebola Outbreak in Liberia and Sierra Leone, available at www.ipinst.org/wp-content/uploads/2016/06/1606_Governance-and-Health.pdf

1) Mistrust of authorities: During the Ebola outbreak, many local people in Sierra Leone expressed mistrust towards the government and healthcare authorities. This was due to perceived misinformation, lack of transparency, and the heavy-handed enforcement of quarantine measures.
2) Cultural practices and beliefs: Some local customs and beliefs, such as traditional burial practices involving the touching and washing of the deceased, were seen as contributing factors to the spread of the virus. This created tensions between public health recommendations and cultural norms.
3) Stigma and discrimination: Those affected by Ebola or suspected of having the virus faced significant stigma and discrimination within their communities. This led to many people hiding their symptoms or avoiding seeking medical care, further exacerbating the outbreak.
4) Economic impact: The Ebola outbreak had a severe economic impact on local communities, as businesses were shut down, markets were closed, and many people lost their livelihoods. This contributed to a sense of hardship and resentment among the population.

COVID-19 Pandemic (2020 - present):

1) Awareness and adherence to preventive measures: During the COVID-19 pandemic, there were concerns about the local population's awareness and adherence to preventive measures, such as mask-wearing, social distancing, and hand hygiene. This was influenced by factors like access to information, cultural beliefs, and socioeconomic conditions.
2) Mistrust and conspiracy theories: Similar to the Ebola outbreak, some local people in Sierra Leone expressed mistrust towards the government's handling of the pandemic and were susceptible to conspiracy theories about the origins and severity of COVID-19.
3) Socioeconomic impacts: The COVID-19 pandemic exacerbated the economic challenges faced by many Sierra Leonean communities, leading to increased poverty, food insecurity, and disruptions to education and healthcare services.
4) Resilience and community-based responses: Despite the challenges, some local communities in Sierra Leone demonstrated resilience and developed community-based strategies to address the impacts of the pandemic, such as mutual aid initiatives and local-level public health campaigns.

It is important to note that the perceptions and experiences of local people in Sierra Leone during these outbreaks were diverse and varied, influenced by factors such as socioeconomic status, cultural backgrounds, access to information, and trust in authorities.



The diagram above shows the response of the presidential Ebola task force in Sierra Leone. The structures were formed to respond to cases detected, but the local people still found it very difficult to accept the realities of the outbreak. Instead, they associated the outbreak with witchcraft, that caused a lot of deaths because they buried their dead without protection (Ebola Virus Disease Protection Rules).

1.1 Statement of the research problem

The COVID-19 pandemic has highlighted the critical importance of effective global health governance and the central role that the World Health Organization (WHO) plays in coordinating international responses to health emergencies. However, the WHO's handling of the Ebola outbreak in West Africa from 2014 to 2016 and the early stages of the COVID-19 pandemic has been criticized, raising questions about the organization's ability to fulfill its mandate.

The 2014 - 2016 Ebola outbreak in West Africa was the largest and most complex Ebola epidemic in history, affecting primarily Guinea, Liberia, and Sierra Leone. The WHO was slow to declare a Public Health Emergency of International Concern (PHEIC), which delayed the global mobilisation of resources and response efforts. Coordination and information-sharing between the WHO, national governments, and other stakeholders was also widely criticised as inadequate.

Similarly, the WHO faced challenges in the early stages of the COVID-19 pandemic, being accused of being too deferential to China and slow to declare a PHEIC, which may have contributed to the virus spreading more widely before global action was taken.

These events raise important questions about the WHO's role, structure, funding, and decision-making processes in global health emergencies. As the lead international organization responsible for protecting global public health, it is crucial to examine how the WHO can be strengthened to better fulfil its mandate and coordinate more effective responses to future pandemics and health crises.

1.2 Hypothesis

The immediate involvement with a more responsive and holistic approach by the World Health Organisation through efficient global health governance initiatives would have stopped the spread at an initial stage. Therefore, on the other hand, the late response or involvement of WHO and its international partners was a contributing factor to the massive spread of the Ebola outbreak in Sierra Leone.

1.3 Research questions

The specific questions this study aims to answer are:

1) What has been the relevance of the global health governance initiative and its involvement in the fight against infectious epidemics like the EVD and COVID-19 Virus?
2) What has been the role of WHO and the international community in stopping the spread of EVD and COVID-19 outbreaks and preventing future outbreaks?
3) What has been the impact created by such a structure?
4) What were some of the challenges faced by this initiative in their involvement in the fight to end the outbreak and prevent a similar reoccurrence in the future?
5) Are there ways that will prevent and further solidify the involvement made by such a governance system in the outbreak in Sierra Leone

2. Methodology

2.1 Research design

The study, with the main aim of assessing WHO in its role in the global health governance system and its impact on the Ebola outbreak in Sierra Leone, is applied social research that made use of both qualitative and quantitative tools like questionnaires and personal interviews in its empirical investigation. This was to explore a wide range of options to reach more valid and reliable results. The researcher used both qualitative tools and documentation in exploring provisions made by both national and international instruments, as well as personal interviews, to obtain the opinions, perceptions, and judgement of the people about the effectiveness of policies as they are implemented.

2.2 Population size

The geographical limitation of the study is Freetown, the capital city of the Republic of Sierra Leone, hosting not only a high number of people migrating from the provinces but also most of the government ministries, departments and agencies (MDAs).

2.3 Sample

Two specific sampling techniques were used to get respondents from whom information was elicited: simple random and purposive.

2.3.1 Simple random sampling

Simple random sampling was used to elicit information from a wide range of respondents. For this purpose, questionnaires were administered using the face-to-face method of completing questionnaires. When these respondents were reached, their consent was sought before putting them into groups and the questionnaires were administered to them so that they could fill them based on their personal views and opinions.

2.3.2 Purposive sampling

Purposive sampling, as a technique, was also used by the researcher to get responses from experts, including medical doctors and other health professionals. Civil society organizations and private health facilities were also consulted, and responses from heads and staff in these various areas were recorded. These people were purposively selected based on their wealth of experience on health issues in Sierra Leone with a background in global health governance.

2.4 Sample frame and sample size

In order to have more valid and reliable data during the conduct of the study so as to enhance a more comprehensive analysis of global health governance and its impact on the Ebola outbreak in Sierra Leone, the selection of respondents was seen as critical by the researcher and therefore had to include in the sample frame:

Health experts, representatives from WHO, professional medical doctors and other medical practitioners, and civil society members, including members of the fourth estate. Below is a table showing the frame and a specific number of respondents taken from each frame.

Frame	**Number**
Health experts	5
WHO representatives	5
Medical doctors	10
Nurses	15
Civil society members	15
Other Sierra Leoneans	20
Total	70

The choice of the above is predicated on the assumption that reliable and representative viewpoints and opinions will be captured and will inform the study.

2.5 Research instrument

In carrying out this research, the following instruments were used to collect data:

2.5.1 Documentation

Considering the nature of this study, this instrument was critical to exploring issues bordering global health governance using the international community as a background. The researcher, therefore, with the aim of exploring a wide range of issues around the subject matter, read pertinent documents from various libraries and also got some scientific publications from the e-library for a thorough and more detailed review of the literature and also giving a background on such framework.

2.5.2 In-depth interview

This aspect was used to get information from experts involved in the field of global health governance and issues of national concern when it comes to health. This method was also used to elicit information from other stakeholders at WHO. This was to ensure critical data was collected to explore key issues bordering the area under study.

2.5.3 Questionnaire

As one of the main tools used, it was used to elicit information from all the various groups of respondents that made up the sample frame. The data obtained through this method immensely helped in both the qualitative and quantitative approaches used in the data analysis.

2.6 Data collection procedure

Data used in this study was collected through reading documents, records and articles to get information. Enhancing this was not easy, so the researcher had to employ the usual commitment of visiting research areas frequently.

Since having respondents participate in research sometimes proves to be difficult as the targeted institutions tried to maintain a cordon of secrecy as a result of the sensitivity of their dealing, the researcher used regular visiting methods to the research community to get information from research participants.

2.7 Sources of data

A combination of both primary and secondary sources was used to conduct this research. Secondary data, including published and unpublished works, internet sources, journal articles, reports and other useful sources, were used, and primary sources, including interviews, were key in the field under study. These were all used in a bid to treat justice to the topic under review.

2.8 Data analysis

All responses given by respondents during the course of the study were captured either by tape or through the questionnaires administered. These were serialized, and the information on the questionnaire was coded and later transferred into SPSS, which was used to analyze the data obtained during the course of the study.

To ensure that a valid interpretation of data is guaranteed, the study used simple statistical tools such as charts, percentages, and tables to illustrate the findings collected from the field. Some comparative analyses were done in the following chapter based on what has been discovered so far using this methodology.

2.9 Validity and reliability

To enhance more valid and reliable data, the researcher has, among other things, identified key units in the sample frame responsible for global health governance. Each of these units has been represented so as to explore the views of these respondents with a view to clearly discern the current operations of the framework.

Key ethical issues were also incorporated during the study in a bid to provide the highest respect for subjects and also not to conclude on anything that may possibly have a negative impact on the audience for which this study was commissioned.

Possible errors were also taken care of during the pilot survey, during which the data collection instruments (questionnaires and interview schedule/guide) were pretested. Suggestions were accommodated from other experts in the field as to the objectivity of the tools and how relevant and strategic the questions were in exploring issues on global health governance and its impact on the Ebola outbreak in Sierra Leone.

3. Presentation of findings and analysis

3.1 Introduction

This section is an in-depth analysis and discussion of the findings gathered from the empirical investigation done during the course of the study.

Table 1: Total number of questionnaires distributed and collected

Category Distributed	Number Distributed	Total Number Collected
Ministry of Health	25	25
Other professionals	20	20
Civil society members	15	10
Total	60	60

Source: Questionnaires.

There were three categories of respondents to the researcher-administered questionnaires, and in-depth interviews were conducted with them whilst conducting the study. For each of these categories, a certain number of questionnaires were administered, and the same number was collected as a result of the researcher's face-to-face method of filling questionnaires. In total, 60 questionnaires were administered, and the same amount was collected. Thus, these questionnaires were used to present the findings and discussions in this chapter.

3.2 Demographic of respondents

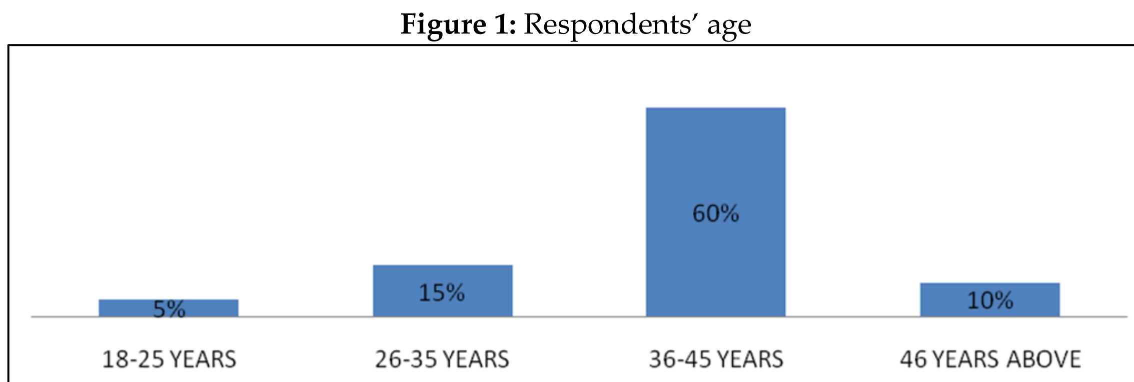
This section gives an account of the demographic of respondents from whom information was elicited during the course of this study. The areas captured in this demographic are as follows:

- Age of respondents,
- Sex of respondents, and
- Respondents' education.

3.2.1 Demographic one: respondents' age

Different age brackets were provided by the researcher, considering the wide range of responses needed by the study. The graph below shows the age differences of respondents who took part in the study.

Figure 1: Respondents' age



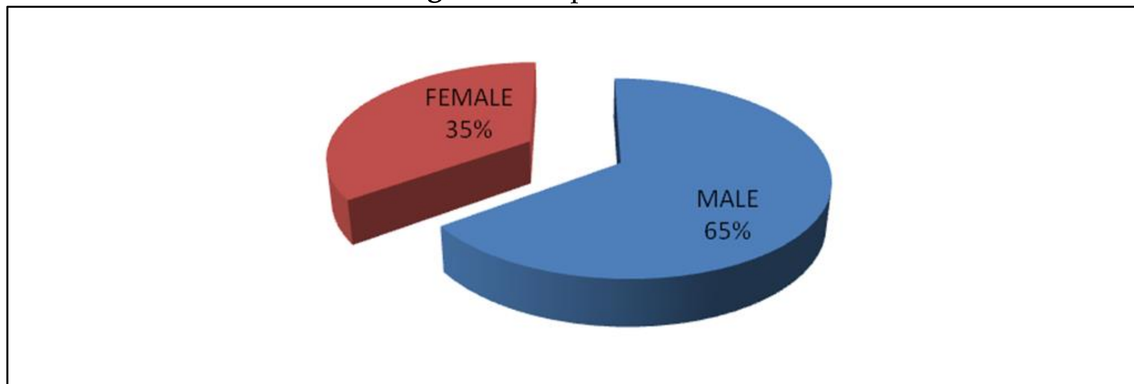
Source: Questionnaires.

60% of respondents fell between the ages of 36-40 years and following them were those between the ages of 26-35, with 15% representation during the course of the study. This shows that most respondents contacted whilst conducting the study had experience with the issues put before them, considering their ages and the time that would have been spent in their various offices.

3.2.2 Demographic two: respondents' sex

The researcher wanted to know the sex of respondents in a bid to know the level of representation for both men and women during the study. The pie chart below shows the findings:

Figure 2: Respondents' sex



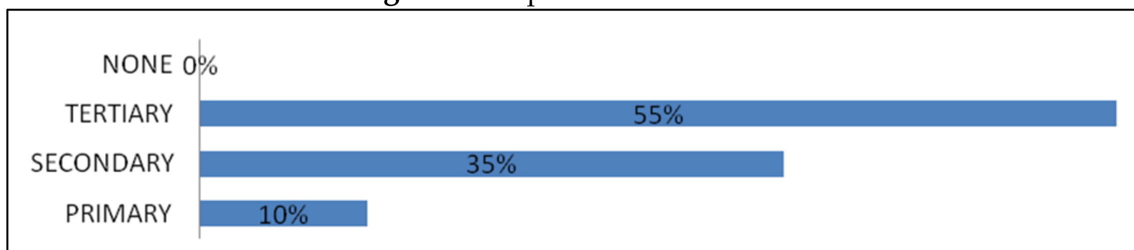
Source: Questionnaires

65% of the respondents were male, and the remaining 35% were female. This shows that males participated more than women in the study.

3.2.3 Demographic three: respondents' education

The study also took into account the educational level of respondents. The researcher was able to get this by asking respondents to state their level of education. The chart below shows the findings:

Figure 3: Respondents' education



Source: Questionnaires.

As shown in the graph above, there were four different levels of education created by the researcher. 55% of respondents during the study had attained tertiary education. Following them were 35% who had attained secondary education, and only 10% had primary education. This shows that the majority of respondents had attained tertiary education, and this will further enhance an informed point of view in their respondents, which will, in turn, inform the results gathered during the course of the study.

3.3 Findings from the literature review

The findings from the literature reviewed have spanned across the conceptual framework on health governance, health as a security and foreign policy, thereby showing its relevance to the world population, four key functions of global health governance respectively, global health governance and its implications on the right of health and finally challenges faced by global health governance.

On the conceptual framework, Dodgson *et al.* (2002) opined that governance could be seen as numerous actions taken and unanimously adopted by a society in a bid to promote actions that are collective in nature and those that will ensure collective solutions in pursuit of a common goal. This has shown that issues regarding GHG are not nationalistic in nature but rather global to enhance the general good. The explanation given denotes the actions of human beings as individuals and also groups, respectively relative to putting modalities in place that will fine-tune and prompt progress on this drive. From this contribution, it could be noticed that there seem to be dynamics involved in putting this definition into practice. Therefore, in the review, the author politely suggests that these actions taken by a united force could include agreement on a range of matters, including membership within the cooperative relationship, obligations and responsibilities of members, the making of decisions, means of communication, resource mobilization and distribution, dispute settlement, and formal or informal rules and procedures.

On perceiving health as security and a matter of foreign policy, the review from Kickbusch (2002) found out that the concept could mean "those health issues that transcend national boundaries and governments and call for actions to influence the global forces that determine the health of people. In her contributions from the review, it is noted that GHG is very important and is seen as a crucial governance system that caters to the health of not only a specific set of citizens or classes but also global health. It was further noticed from the review that GHG, among many other things requires new forms of governance at national and international levels, which seek to include a wide range of actors coming from different disciplines and levels.

Other contributors to this in the review have been Nora and Jennifer (2011), who are of the opinion that health issues have also been factored into security matters considering the dynamics involved, and this has been concentrated on securing borders against infectious diseases and other forms of bioweapons. This approach, she further stated, as found out in the review, has, however, not taken into consideration non-communicable diseases and also their social determinants of health. As a result, there have been surveillance activities in an attempt to control outbreaks and their negative consequences on the security of states. Bioterror, as found out by the review, has also been seen as another reason for having a GHG system. As discovered by the review, this bioterror could even be seen as the factor responsible for the Ebola outbreak in Sierra Leone, Guinea and Liberia, respectively, as postulated by specific authors.

As a matter of foreign policy, the review revealed that there has been some amount of bias in the way GHG is enhanced; this bias, as displayed by many key institutions and organizations responsible for global health governance, could undermine WHO's moral authority to elicit cooperation from developing states. As noticed and very clearly explained in the review of literature, this, however, could be another problematic development because the effectiveness of surveillance and response depends largely on poorer states' ability to detect and verify outbreaks as and when they erupt. It is therefore believed that should such bias continue to prevail, it could also frustrate the effort made

by poorer states in displaying their total willingness not only to cooperate but also to motivate and develop standardized procedures that will address issues of infectious agents and basically all their origin in their areas. This, without doubt, will have huge implications for security, which has been considered a global concern.

On the aspect of elaborating on the key functions of GHG, the review found out that there could be many benefits a state could have through such a governance system, and key among these, as discovered, could be: "*to the maximum its available resources, to achieve progressively the full realization of the rights recognized in all human rights documents, conventions and protocols*". In addition to this, as spelt out in the review, it would define "*minimum core obligations*" from which this progressive realization would proceed, ensuring "*the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups… access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone… access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water*."

However, the challenges noticed and discovered in the review on GHG and its effectiveness and efficiency are:

Lack of coordination between donor governments, NGOs, and recipient countries;

- Confusion of norms and activities due to different ideas regarding health rights and obligations;
- Lack of coordination between WHO, WB, other UNOs and multilateral organizations;
- Lack of national health plans in recipient countries or plans that do not provide for donor coordination;
- Donor neglect of recurrent expenditures;
- Donors' short-term orientation and lack of middle- and long-term commitments;
- Health aid tied to foreign policies of donor or recipient or to purchases of supplies from donor countries; and
- Criteria of "self-reliance" and past performance, channeling aid away from the neediest countries

3.4 Findings from empirical investigations

As stated in the introduction of this chapter, there have been two different types of findings: those discovered during the literature review and others from empirical investigations done on the specific objectives of the study. This section, therefore, presents findings from the empirical investigations done.

3.5 Relevance of WHO and the global health governance initiatives in the fight against epidemics and infectious viruses like Ebola

As a result of some desk reviews done in line with the objectives of this study, it could be evident, based on the findings, that the emergence of GHG was due to the numerous lapses noticed with International Health Governance, which in itself evolved as a result of human interactions across national borders way back before the mid-nineteenth

century. Considering its actors being mostly state-related and actions also considered purely institutionalized, there started to grow issues between some rich and poor countries who also thought they should be equally treated. This was seen as challenging because the whole system was seen as state-centric. Even though non-state actors were given some role to play in the IHG system, the majority of responsibilities and facilities in decision-making were conferred on state actors. This calls for a rethink, as many scholars have argued, because everyone must come together with hands-on deck in matters regarding health, which forms the basis of security around the world. Thus, globalization, among other issues, prompted debates around a global health governance initiative which many thought could be more encompassing and involving than just taking on board state actors.

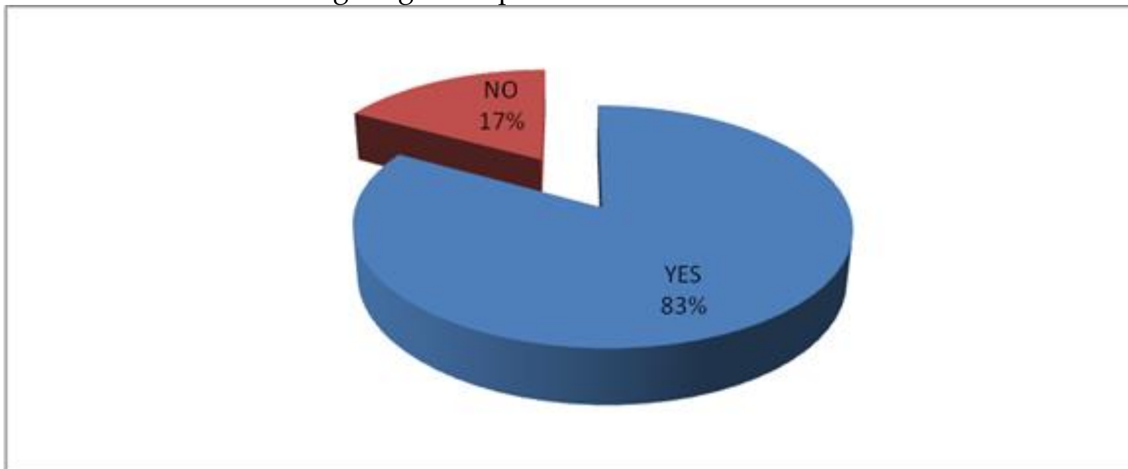
According to interviews conducted, it could be understood that contemporary health risks and opportunities may not just send a clearer and more comprehensive of security taking into account issues around health. Therefore, health-related concerns cannot be solely handled by just states at the national level, considering the proliferation of cross-border and trans-border flows of people, goods and services, and ideas. It has been seen by many that the need for more effective collective action by governments, businesses, and civil society to better manage these risks and opportunities has, therefore, forced stakeholders to examine factors and other determinants responsible for effective and efficient health policy and practice at the sub-national, national, regional and global levels.

From many investigations that have been done, what has been seen is the fact that many issues outside the health sector have also been creating daunting challenges for an efficient and effective sector that caters to the majority. Key among these issues have been but not limited to, the following: trade and investment flows, collective violence and conflict, illicit and criminal activity, environmental change and communication technologies.

Irrespective of that fact, many are of the view that there is a desperate need to broaden the public health agenda in a way that captures these globalizing forces highlighted above and to ensure that the protection and promotion of human health is placed higher on other policy agendas. Thus, it is clear, stemming from the current challenges posed, that International Health Governance (IHG) does not sufficiently meet the needs of contemporary health issues. This, among others, has necessitated the introduction of what has been referred to as the GHG system.

Given this backdrop, respondents in their view were asked to state whether the WHO and the global health governance initiative have been relevant to the fight against epidemics with a specific reference to the Ebola outbreak in Sierra Leone:

Figure 4: Relevance of WHO and the global health governance initiatives in the fight against epidemics and infectious viruses like Ebola



Source: Questionnaires

83% of respondents mentioned "Yes" that WHO and the GHG have been very instrumental and relevant in the fight against the epidemic, whilst the other 17% of respondents mentioned 'No' that WHO and Global Health Governance have posed no relevance. This, however, has shown that GHG has been very relevant in the fight against epidemics, with the Ebola outbreak as a case study.

Respondents were, therefore, asked to state reasons for their answers to the above question. Among the 60 respondents contacted during the course of the study, about 20 of them mentioned that GHG serves as a way of dismantling how people have been thinking about issues regarding the promotion of health to which WHO has played a great role. That is to say, it shows the need for many stockholders to start thinking of addressing factors which, in their view, cross and even ignore the geographical boundaries of states with a focus on preventing and immediately responding to health issues. According to them, it could be evident that the establishment of the International Health System considered the state as the core and, therefore, fought hard to protect the integrity of states. The role played by WHO and the GHG concept has seen focusing on the state as not being fair owing to the fact that there have been a lot of other issues to handle other than just the interests of the state. IHG has, therefore, been historically focused on those health issues that cross national borders, with the aim of protecting domestic populations within certain defined geographical boundaries through such practices as quarantine, cordon sanitaire, and internationally agreed standards governing the reporting of infectious disease, trade and population mobility. All of these efforts have been focused on the point of contact, the national border of states, thereby leaving those weaker states that could not adequately do this prone to many interferences and even volatile situations. However, with the effective guidance of WHO through its practice of GHG, it could be seen that all protocols regarding the state and its representation are seen as not too necessary but rather put to the fore the following as core reasons why there needs to be a change of concept and operations from IHG to GHG: worldwide flows of information and communication across the Internet; the ecological

impacts of global environmental change; the frenzied exchange of capital and finance via electronic media; the illicit trade in drugs, food products and even people; and the global mobility of other life forms (e.g. microbes) through natural (e.g. bird migration) and manmade (e.g. bulk shipping) means render border controls irrelevant. Some of the above are caused by certain countries, but the impact crosses borders and disturbs the health of other countries. If this is done, they asked why controlling them should become an issue of a state.

Another 20 of these respondents mentioned that WHO, in its GHG, stresses the need to define and address the determinants of health from a multi-sectoral perspective. According to them, a global system of health governance begins with the recognition that a broad range of determinants impact population health, including social and natural environments, and this has been argued by many scholars. Many of these respondents tried to refer to recent decades that have experienced the involvement of other professionals and experts in matters touching on health. It has, therefore, warranted the recognition of other forms of expertise in health policy making (e.g. economics, anthropology) and links with other social sectors (e.g. education, labour). This is why there have been many publications on how ministries of health and international health organizations have sought to engage more directly with sectors traditionally seen as relatively separate from health (e.g. trade, environment, agriculture) in recognition of "cross-sectoral" policy issues at play and WHO taking the lead in all of these. Informal consultations between WHO and WTO will have a primary focus on dealing with problems facing the health sector. This has, therefore, in the views of some respondents, yielded some dividends, which is why, in their view GHG is relevant.

Another 20 respondents stated that WHO and its GHG are relevant in a way that it indicates the need to involve, both formally and informally, a broader range of actors and interests than just state representation as it was in the case of IHG. In their view, they continued stating that the existence of IHG had seen only states as key players and, therefore, limited its definition to statehood. This is why it has permitted as key players only the following organizations: PAHO, the European Union), along with major international health organizations such as WHO and the World Bank, etc. This focus, in the respondents' view, has further debilitated and deteriorated the health conditions of states that have not been able to meet the dynamics involved in maintaining the standard expected of them. An instance was mentioned with respect to the initial stance taken by some developed states by refusing the entrance of citizens from Ebola-affected areas. In their view, the refusal was not in place, considering the shared responsibility assumed in the GHG system.

3.6 Structures put in place by WHO through the global health governance initiative not only to end the spread of the virus but also to prevent future outbreaks

In an attempt to find out why epidemics around the world, there have been many scholars who are of the view and opinion that the combination of rapid urbanization and the growth of largely unregulated settlements, significant economic and social

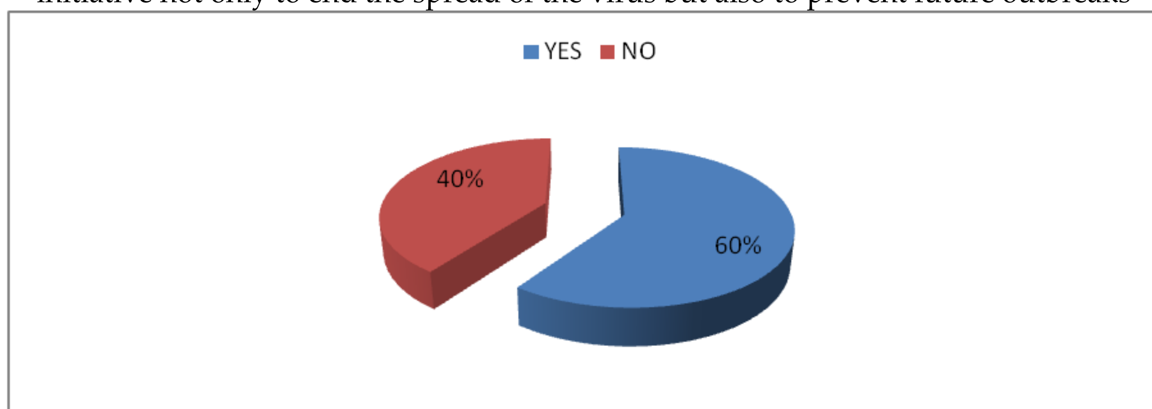
inequalities, and large-scale ecological changes among others have increased the likelihood of epidemic outbreaks around the world. Even though this view is considered by many, there have also been others who contradict this view on the basis that population growth should be parallel with developmental plans, especially those connected with security. This section, however, tries to explore the structure that has been put in place, if any, to prevent the spread of Ebola as being part of epidemics that have seriously threatened the survival of many.

In exclusive interviews with a health worker in Freetown, it was made clear that the effort to stop the spread of epidemics and prevent them is not anything new. On the whole, she continued stating that there has been a lot done by WHO through its global health governance initiative to strengthen what has been commonly referred to as global security and among these strides have been the creation of international institutions and surveillance systems to detect such epidemics that may pose a threat to human survival and the development of vaccines.

However, despite the existence of this structure, there was an outbreak, and it spread to various countries, especially in West Africa and its environs. Clearly seen and noticed was the weakness in the structure that was believed to be above to address epidemics put in place by WHO adequately. Interestingly, others were still of the opinion that no structure was put in place as the EVD took the international community by surprise. During the study, it also became clear that the structure in the form of national health systems in third world countries like those in West Africa where such outbreaks are possible to occur had no means set to adequately respond to such infectious diseases, with Sierra Leone not being an exception.

Respondents were, therefore, asked to state whether, in their view, there was any structure put in place to end the outbreak.

Figure 5: Structures put in place by WHO through the global health governance initiative not only to end the spread of the virus but also to prevent future outbreaks



Source: Questionnaires

60% of respondents mentioned Yes, that there was a structure put in place to end the spread of the virus. Other 40% did mention No, that there was not any structure put in place to end the virus. This, however, shows that there was a structure put in place.

In desk review, it was discovered that the structure put in place by WHO was a mixture of approaches through the establishment of various committees that were tasked to assess the existing structures and why they spread with a responsibility to proffer recommendations that will help. As the world-leading organization in health issues, the WHO, upon discovering the spread, had to set its objectives, and these were five key objectives:

- Stop transmission of the Ebola virus in affected countries,
- Prevent new outbreaks of the Ebola virus in new areas and countries,
- Safely reactivate essential health services and increase resilience,
- Fast-track Ebola research and development,
- Coordinate national and international Ebola response x of WHO governance reform recommendations post-EVD.

At the international level, there was this structure put in as indicated by the table below. This table shows the name of the panel, entity, number of members and recommendations respectively:

Table 2: Panels/Commission name that were recommended in the fight to end the outbreak

Panel/ commission name	Entity	Number of members/ recommendations
WHO Interim Assessment Panel	Established by the WHO Executive Board comprised of a mix of independent experts	- Date issued: May 2015 - 5 members - 21 recommendations
Harvard-LSHTM Panel	Establishment by Harvard Global Health Institute and London School of Hygiene & Tropical Medicine primarily from academia, foundations, think tanks, and NGOs	- Date issued: November 2015 - 22 members - 10 recommendations
CGHR	Established as an independent commission with the National Academy of Medicine as a secretariat funded by foundations and agencies. The commission comprised members from different countries, foundations, and entities.	- Date issued: January 2016 - 17 members - 26 recommendations
Kikwete Panel	Established by the UN Secretary-General comprised of political representatives of member states	- Date issued: January 2016 - 6 members - 27 recommendations
WHO Advisory Group on Reform of WHO's Work in Outbreaks and Emergencies	Established by the WHO Director-General to offer guidance on the organization's emergency reform process. Group chaired by UN SG Special Envoy on Ebola and various members from UN agencies, NGOs, representatives of government health agencies, and others.	- Date issued: January 2016 - 19 members - 9 core recommendations in its second report

Source: Taken from a WHO publication on Emergency Guidance[iii]

[iii] A WHO Emergency Guidance Surveillance strategy during Phase 3 of the Ebola response 5 November 2015 available at http://apps.who.int/iris/bitstream/10665/192997/1/WHO_EVD_Guidance_Sur_15.1_eng.pdf?ua=1

As can be noticed in the table, all of these panels did send in recommendations that will help end the outbreak and also prevent the spread of the disease in not only West Africa (Sierra Leone and Liberia) where many deaths were reported, but also in other parts of Africa and the world at large. Key among the recommendations they proffered were the following as taken from this same publication:

Table 3: Emergency Guidance from WHO

REFORM PROPOSAL	WHO INTERIM PANEL	HARVARD -LSHTM PANEL	CGHRF	KIKWETE PANEL	WHO Reform Advisory Group	WHA69
Establish/support emergency contingency fund[a]	✓		✓	✓	✓	✓
Establish program/center for health emergency preparedness and response[b]	✓	✓	✓	✓	✓	✓
Increase WHO assessed contributions[c]	✓	✓	✓	✓	✓	
Establish/support Global health emergency workforce	✓			✓		✓
Develop mechanisms to enhance cooperation with non-state actors[d]	✓	✓	✓	✓	✓	✓
Develop a framework of norms and rules for research for disease outbreaks and global financing facility		✓				
Require time-bound governance reforms to focus WHO on core functions		✓				
Establish an independent Pandemic Product Development Committee and secure R&D funding			✓			
WHO coordination on prioritizing global R&D for health crises and management of international fund				✓		
WHO leads renegotiation of international instruments to include novel pathogens[e]				✓		
WHO establishes a "blueprint" for research and development of infectious disease threats and epidemics						✓
Consideration of a UNSG Special Representative or UN Special Envoy for health crises	✓					
Establish independent UN Accountability Commission		✓				
Utilize the UN OCHA for outbreaks that become humanitarian crises	✓	✓				✓
Creation of Global Health Committee within UN Security Council		✓				
UNSG leadership in partnership with WHO for sustaining health systems in fragile states			✓			
Escalation process facilitating UNSG control over health emergencies when necessary			✓			
Creation of High-level Council on Global Public Health Crises				✓		
Establish clear line of command between WHO and UN system in event of an outbreak that is a humanitarian emergency[f]				✓	✓	✓

Key
Red: Internal governance reforms or new mechanisms within WHO structure
Blue: Reforms focused on greater involvement of United Nations
Notes:
[a] WHO Interim Panel suggested funding through voluntary contributions. CGHRF recommended one-off initial contributions assessed pro rata with core assessed contributions. Kikwete Panel recommends10% levy on voluntary contributions to finance fund.
[b] WHO Interim Panel, CGHRF, and WHO Advisory Groups supports creation of an independent board to oversee center. CGHRF also supports increase in member state assessments to fund center. Kikwete Panel recommends establishment of a multi-sectoral standing advisory board to guide center activities.
[c] Harvard-LSHTM Panelrecommended new "untied" funds for WHO regular budget in exchange for implementing good governance reforms
[d] Harvard-LSHTM Panel recommends Executive Board conclude work on WHO Framework of Engagement with Non-State Actors as part of good governance reform recommendations. WHA69 adopted Framework for Engagement with Non-State Actors.
[e] Recommendation specific to renegotiation of Pandemic Influenza Preparedness Framework and balancing it with principles of Negoya Protocol to the Convention on Biological Diversity
[f] WHO Advisory Group primarily focuses on better coordination between WHO Programme for Outbreaks and Emergencies, the Inter-Agency Standing Committee, and Global Health Clusters for health and humanitarian coordination.

Source: Taken from WHO (2015) Emergency Guidance

Notwithstanding the above, at the national level, there were multiple approaches. Among these were those taken by the government of Sierra Leone and that of the

international community. These were put together through a concerted effort and the following framework was put in place:

A. District coordination

It was discovered that WHO had to further strengthen district surveillance, risk assessment and response operations, and in the process, ensured that all districts had a flexible plan specific to their epidemiological situation and social/anthropological context with a robust approach to handle the spread when the need arises. As part of their actions, WHO also ensured the shift response in the form of service delivery to families and all communities affected by the epidemics, and this was to ensure, among other things, trust with communities. As seen necessary, through the support of other donor partners, the capacity of staff at the national district level was improved with a view to strengthening cross-border operations and early detection.

B. Active surveillance

Active surveillance and contact tracing were also seen as important in all the interventions made by WHO, and this was done for every suspected Ebola case. This activity was positive, considering the integrated approach used at both public and private facilities. Other areas that were seen as potential risk areas were also surveillance and actions taken on outcomes given by such surveillance system that was put in place.

WHO and its partners did provide the capacity needed to conduct integrated epidemiological case investigations through anthropological contributions and engagement with communities to establish transmission chains and identify contacts. These contacts identified were closely monitored for a period of 21 days, even where the required crossing of national and international borders.

C. Community engagement

WHO, together with the government and other development partners, saw the need to involve communities and their stakeholders in the whole process. This, therefore, witnessed communities being mainstreamed in the survival delivery system catered for during the outbreak, and these included the following: the training of frontline staff in trust building and communication skills and re-orientating social mobilization activities to address service uptake.

In addition to the above, there was also the platform created to strengthen technical inadequacies and well as operational duties with specific reference to departments of health and education, which was believed to create an impact on awareness raising and sensitization. Respectful and timely engagement of communities before and during critical response events, such as case investigations and burials, positively impacted the prevention process of the spread, thereby mitigating community resistance and ensuring support for and the safety of operations. There were also tailored and targeted strategies meant to engage with different groups of chiefs, religious leaders,

women and youth in a bid to create awareness and other structures that would stop the spread of the disease.

D. Optimized case management

One key approach used by the WHO, the government and other development partners in ending the spread of the disease was building trust in the ways cases were managed during the spread of the disease. This platform was created to provide trust and a higher standard of care for those who were suspected of having contracted the disease. It also provided updates on their progress in terms of recovery. This was effective through the establishment of community liaison officers who were stationed at treatment centers. Case management capacity, triage and infection control procedures were optimized to increase survival rates as well as to reduce the number of health workers becoming infected with the disease. This additionally provided the belief that if someone did adhere to the precautionary measures stated, the chances of survival could be great. The distribution of medical facilities and items was based on the severity of each district, and this also contributed to improving the recovery rate of many suspected cases.

When cases were gradually reducing, WHO, together with its partners, started decommissioning and/or repurposing ETUs and community care centers that no longer required patient isolation and also embarked on a massive redeployment of foreign medical staff to assist with the safe reactivation of essential non-Ebola and Covid-19 healthcare services thereby as required using existing Ebola treatment centers to conduct clinical trials of new treatments, studies immediately started in connection with health complications of survivors to inform the treatment and care that should be given to these sets of people.

Finally, in assessing the structure, respondents were asked to state the level of effectiveness of these structures that were put in place by both national and international stakeholders.

Figure 6: Optimized case management

Source: Questionnaires

30% of respondents stated that the measures that were in place to stop the spread of the virus and prevent its reoccurrence have not been too effective. It was evidence, according to respondents that WHO failed to achieve the "evolution" in global health governance needed in order to ensure that global society is adequately protected against the multifaceted and increasingly complex nature of modern public health emergencies with specific reference to the Ebola and Covid-19 outbreak. According to these respondents, had there been any proper and accurate measures put in place, there would not have been the spread of the disease in other countries as it happened in the sub region. This, however, in their views, just showed the inadequacies relative to GHG with specific reference to structures that have been put in place.

3.7 Impact created by the World Health Organization through such a structure during the Ebola and COVID-19 outbreaks in Sierra Leone

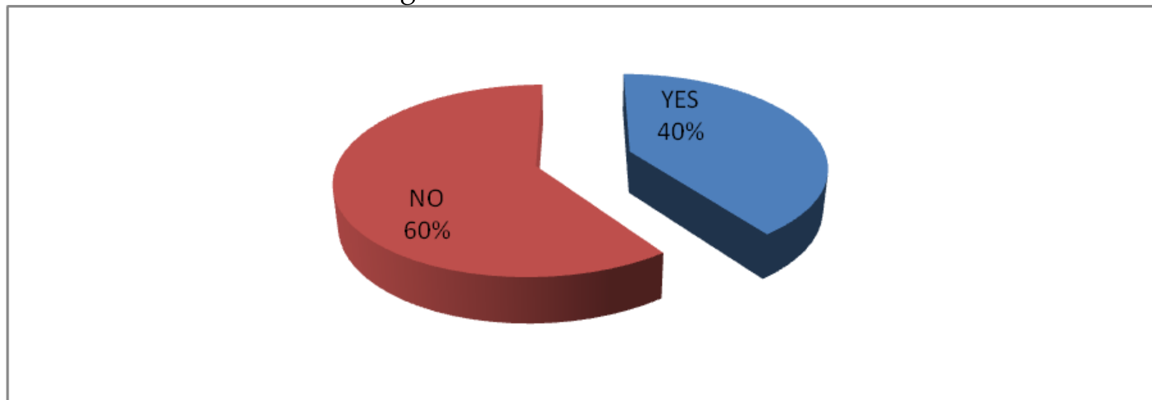
Despite the current situation, there has, however, been a structure put in place by the WHO to enhance global health governance. Apart from the subject under review and the COVID-19 outbreak, there are other areas where some impacts have been created in connection with tackling epidemics and key among these have been the emergency plan for AIDS relief and that of other global funds to fight against AIDS, tuberculosis and Malaria with specific focus on third world countries. Looking at the situation from another angle, issues of corruption and other inadequacies have served as a stumbling block to the proper functions and impact created therein in this drive. [iv]

On the aspect of epidemics like HIV, many respondents mentioned that GHG has enhanced the availability of and access to HIV services, improved the quality of services, and strengthened health information systems and the role of non-state actors in health care. Thus, however, there have been some negative outcomes, such as not investing significantly in the production of new health workers and the system not being able to address misdistribution problems. It could also be seen that the slow response made by the GHG system has also contributed significantly to the internal brain drain by luring health workers from the public sector to non-governmental organizations, thereby increasing the workload for existing health workers. Many have referred to this as poor policy direction, strategic planning and coordination. If this long outstanding epidemic is still being grappled with by the global health governance system, what then becomes of Ebola and COVID-19 which to many seems more dangerous than AIDS and other epidemics the international system has been struggling with? This section however assesses the impact that has been created by the global health governance system.

The researcher therefore tried to ask respondents whether there had been any impact. The view of respondents is captured in the graph below:

[iv] J Glob Health. 2015 Impact of global health governance on country health systems: the case of HIV initiatives in Nigeria, available at https://www.ncbi.nlm.nih.gov/pubmed/25969731

Figure 7: Impact created by the World Health Organization through such a structure during the Ebola and Coviv-19 outbreak in Sierra Leone



Source: Questionnaires.

60% of respondents confirmed that there has not been no impact created by the GHG structure whilst 40% of them mentioned 'Yes' there had been an impact created so far by this structure. This shows that in an event there has been an impact created, they must have been more minimal than expected.

All respondents who mentioned that there had been an impact created based their contributions on the fact that the Ebola virus did come to an end at the time, and without the intervention of the international community, it would have been impossible for the epidemic to be controlled. They further stated that through the intervention of the international community there were other things in the form of measures put in place to prevent further break.[v] This, among others in their view, was an impact of structures put in place; otherwise, the situation would have gotten worse.

On the other hand, those who mentioned no, there has not been any impact. They tried to explain the weak system that was in place, which further gave rise to the spread of the virus even to other neighbouring countries.

This was also not different from a view given by the WHO (2014) in their publication, where they mentioned that it is possible for disease outbreaks and catastrophes to affect countries at any time, thereby as an end product causing substantial human suffering and deaths with huge economic losses. In the event that this has occurred and no appropriate measures are taken in a bid to settle the differences, those affected can be more vulnerable, especially in countries where health systems are weak, like Sierra Leone.[vi]

In a statement at the first meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa, the WHO clearly stated that the Ebola virus disease outbreak in Western Africa then, among other things, highlights how an epidemic can

[v] The economic impact of the 2014 Ebola epidemic: short- and medium-term estimates for West Africa. Washington: World Bank, 2014.

[vi] Strengthening health-system emergency preparedness: toolkit for assessing health-system capacity for crisis management. Copenhagen: World Health Organization; 2012. Available from: http://www.euro.who.int/data/assets/pdf_file/0008/157886/e96187.pdf [cited 2014 Nov 3]

proliferate rapidly and pose considerable problems in the absence of a robust health system capable of rapid and integrated response as should be the case. This was justified in the way the EVD started and, in the twinkle of an eye, caught the attention of the international community who many have argued came in very late. The outbreak began in Guinea in December 2013 and much was not done to ensure that it was stopped at that initial stage. As a result of the neglect by governments in the Mano River Union and even those from without, it soon spread into neighbouring Liberia and Sierra Leone, which share boundaries with Guinea, considering their geographical location. Not much was done even when it started spreading into these countries except when the death rate increased and posed a threat to even other nationals from the West who resided then in these affected countries. Since 2013 in Guinea, it was only in August 2014 that Ebola was declared an international public health emergency issue, which prompted the intervention of many stakeholders around the world to ensure that accurate measures are put in place to stop its spread.[vii]

However, it could also be evidenced that at the time the outbreak began, the capacity of the health systems in Guinea, Liberia and Sierra Leone was limited and challenged by many other issues. Key among these were health practitioners, the basic requirements and requisites tools needed to boom the health sector; ambulances were also problems and the capacity of medical practitioners for such infectious diseases was very low. This did not argue well as many fell prey to some of the exigencies created therein as a result of unprofessional conduct and lack of knowledge to handle such a complicated epidemic adequately.

Several health-system functions in all three countries that were generally considered essential were not performing well and this hampered the development of a suitable and timely response to the outbreak which needed a more robust and stable health system. There were inadequate numbers of qualified health workers in all the areas who could have effectively and efficiently handled cases that were discovered early. Had there been, many were of the belief that the disease would not have spread as it did and wrecked in such a mass way the development of the three nations, with more cases reported in Sierra Leone and Liberia.[viii]

In all areas with specific reference to Sierra Leone and Liberia, it became clear to all health stakeholders and the international community that infrastructure, logistics, health information, surveillance, governance and drug supply systems were weak, and this further catered for a more complicated situation especially with porous borders in all these three areas thereby enabling the smuggling of these drugs to other neighbouring countries. The organization and management of health services were sub-optimal. Government health expenditure was low, whereas private expenditure – mostly in the

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[vii] Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa [Internet]. Geneva: World Health Organization; 2014. Available from: http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/ [cited 2014 Nov 3]
[viii] Global Health Observatory [Internet]. Geneva: World Health Organization; 2014. Available from: http://www.who.int/gho/en/

form of direct out-of-pocket payments for health services – was relatively high. Thus, the problem with service delivery became further compounded and difficult to handle adequately.

The World Health Organization in 2012 mentioned that the last decade has seen increased external health-related aid to Guinea, Liberia and Sierra Leone, being referred to as, the least developing countries in the region. However, in the context of Millennium Development Goals 4, 5 and 6, as stated by WHO, most of this aid has been allocated to combat human immunodeficiency virus infection, malaria and tuberculosis, with much of the residual going to maternal and child health services by extension. These activities were done on the understanding that there were still a lot of issues disturbing the sector in all three countries. Therefore, relatively little external aid was left to support the overall development of health systems, as the case may be and even at the beginning of the outbreak.[5] This lack of balanced investment in the health systems of the three countries, many, believed contributes to the challenges of controlling the Ebola outbreak, which could have been tackled at the initial beginning rather than allowing it to have ravaged the lives of people who could have been protected by all means.[ix] It is obvious that a strong health system decreases a country's vulnerability to health risks and ensures a high level of preparedness to mitigate the impact of any crisis, including the Ebola outbreak, which cost the lives of 1131 people in total, as estimated in the diagram below.

Table 4: Countries with Former Widespread Transmission and Current Established Control Measures of Ebola[x]

Country	Total Cases (Suspected, Probable, and Confirmed)	Laboratory-Confirmed Cases	Total Deaths
Guinea	3814	3358	2544
Sierra Leone	14124	8706	3956
Liberia	10678	3163	4810
Total	**28616**	**15227**	**1131**

Just after the disease was declared an end, the response by governments and external partners to a health crisis posed by a communicable disease, such as Ebola, has been based on the lessons led to focus solely on reducing transmission and the effect of the disease to not only fellow nationals within a country but also protecting other countries from contracting such disease. However, such a response has also been considered insufficient by other quarters. Febrile individuals who report to health centers need to be screened for Ebola as part of other measures used to diagnose a certain illness – even if most of them have fevers caused by other infections – and those found to be negative for Ebola still need to be treated rather than simply turned away as the case had been before the outbreak. This is because the symptoms might confuse other professionals and, in the

[ix] ibid
[x] 2014 Ebola Outbreak in West Africa - Case Counts available at https://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html

process, may not be sensitive enough to discover the real signs, except in many cases when these victims had developed additional symptoms other than just fever.

Table 5: Sierra Leone Ministry of Health and Sanitation
Corona Virus Diseases (Covid-19) Situation Report-2021

No	Categories	Total
1	Confirmed cases	3,823
2	Recovered cases	2,571
3	Deaths	79
4	Total Covid-19 test conducted	119,858

The table above shows that one hundred and nineteen thousand, eighty hundred and fifty eight (119,858) tests were conducted by the Ministry of Health. Out of the conducted test cases, there were three thousand eight hundred and twenty three (3,823) confirmed cases, two thousand five hundred seventy-one (2,571) cases were recoveries, and seventy-one deaths were reported.

3.8 Challenges faced by WHO initiatives in ending the outbreak and preventing its spread to other countries

In the event there had been any impact created by the structure put in place, there must have been challenges, which this section tries to explore. Below were some of the challenges faced by the Global Health Governance initiative in not only ending the Ebola epidemic but also preventing it from spreading to other countries.

It is evident that irrespective of the impact already created by the framework, an effective and efficient normative framework upon which GHG could be built and guided by many respondents remains. Still, it could be seen that there is not that consensus among actors at both national and international levels on having ethical principles that will certainly define global health corporations, as the case maybe. There has been the problem of universalism which many believe should be the ethos guiding the conception of social medicine. The approach that has been used by many players seemed to be in conflict with the belief that human rights are fundamental and therefore comprise the accessibility to health for one's survival. The ideas as to how the whole process should go is still a challenge and despite the relative positive impact that has been created, there still lacks the informed discussion and engagement underlying the normative framework that should kick-start GHG in practices, many believe.

In addition to the above, another key challenge could be the absence of a defined leadership and authority in GHG initiated by WHO. It has been discussed in other chapters that the seeming emergence of global health under a governance idea has been populated by multiple actors with different aims and objectives; these actors base their actions on different policies with also various targets. Their mandates have been different, and their resources have been concentrated on multiple areas without a definite authority to guide the process. Even though WHO is considered by many as taking the lead on this, there have still been experienced lapses and other inefficiencies in all its

functions, thereby sending a very negative message as to who has been in charge and where the authority on intervening in the health issues of other countries come from? Therefore, many respondents are of the view that the process lacked leadership and central authority. Clearly noticed has been the refusal of states to pool their sovereignty in the interest of acting collectively through a united approach to end the epidemic and prevent its reoccurrence. There seems to be no corporation and a unique leadership that will provide the justification and basis for generating awareness among actors, mobilizing resources for key interventions, utilizing national resources where the case arises through a more coordinated strategy, setting priorities, handling the issue with legitimacy, among others. Thus, it becomes obvious that the process still faces the challenge of having a single institution that could be formed through a concerted effort by all that has the requisite capacity to address health issues of global concern.

However, the availability of resources, as many believed, has been another key challenge coupled with the difficulties in appropriately distributing the available resources in a manner that meets international cooperation and standards. Without any iota of doubt, it is obvious that the present system is kind of ad-hoc in nature, with a lot of challenges posed in its implementation with reference to shift responses. The willingness of the government to contribute to a system that lacks authority, mandate and definite framework has further compounded the problem

Furthermore, many also believed that the sovereignty of states has also been another hurdle to kick-starting the proper function of health governance on a global platform. There have, however, been some regulations that have been used by other actors to intervene. Nevertheless, in the absence of these regulations, which in practice do not reflect the willingness and global approval of member states from a consensus point of view, how will such a governance process be possible? WHO, which has been taking the lead, is seen to be more recommending than having the authority to command member states to take specific actions that may lead to the effectiveness of the governance system. An instance of this has been the manner in which reports on yellow fever, cholera and plague, for example, are made and the reliance on governments to act, who in many cases have been reluctant to act considering the economic implications such could have on their investment potentials. There has not been any organized approach to monitor and evaluate its successes, which has left room for multiple complications.

4. Conclusion

Despite its shortfalls, there has been some relevance posed by the seemingly WHO interventions in its GHG system that have been put in place to prevent epidemics and their outbreaks. Even though not effective and efficient, as already proven by the study, there is a structure put in place to facilitate this process. There have not been very strategic impacts created but they are considering the success in putting the outbreak in Sierra Leone, Guinean and Liberia to an end. Despite all the achievements made in this drive, there are still challenges this process faces.

5. Summary

Based on the investigations conducted so far, it could be evident that until the 1990s, those responsible for health issues had mostly been state actors and other multinational organizations. The approaches used to settle health issues permitted only states to be involved with very famous organizations. It was not in any way considered a matter that needed the input of all and sundry. Based on critical observations made by academics and other stakeholders, health funding was mainly bilateral, with agreements and other relative matters flowing between donor and recipient governments only with strict limitations as to the involvement of other actors. When it was time to eradicate diseases with special reference to epidemics, it was considered solely the responsibility of national ministries mainly responsible for health and its related issues. Even though there were some leverages given to the participation of other actors, most of these were state actors and no other nongovernmental organizations or individuals. If there was any need to involve other actors, such an opportunity would be given to the WHO and its partners.

It was clear that the system which was in place then (International Health Governance) was not well coordinated to be able to adequately handle issues of global health in not just developed countries, but other third-world countries. The reporting system provided was guided by international health regulations, and this was to report outbreaks. Thus, this system was referred to as "the Multilateral Health regime". Actors who played key roles were very small, with responsibilities clearly spelt out that, in many cases, stopped them from performing other functions that would have positively impacted the way health matters were implemented. It could be ascertained that, as one goes through the challenges of a system, only the interests of powerful Western states were met, so developing countries were not an issue worth critical consideration and intervention. Worst of all, there was no regulation that could force other developed states to act when there was an outbreak. Powerful states did not border what happens to other states and it was considered a matter of sovereignty even where such health issues might have multiple effects on other states. They always felt secure with their advanced medical and administrative capacities and, therefore could adequately prevent and control outbreaks and defend borders from diseases on their own, and did not rely on the IHR to handle outbreaks.

The situation later changed as commonly noticed in contemporary governance are the dynamics in health risks and opportunities which have raised questions as to the complacency that has been shown by developed countries. Clearly, the capacity to influence health determinants, status and outcomes cannot be assured through national actions alone because of the intensification of cross-border and trans-border flows of people, goods and services, and ideas. Hence, the need for effective assessment with collaboration by governments, businesses and civil societies has been seen as crucial to efficiently handle the numerous risks going along with health-related matters.

The need that has been identified has, however, made it clear that the responsibility to ensure the right to health for all lies not only with states and their

obligations to their own people as required by their national constitutions and the principles of sovereignty, among other policies but also with the international community as a key partner considering the implications health issues such as infectious diseases may have in a global village.

Among many other impacts of the decade conflict was the devastating effect on the health sector. On the one hand, the war did not only stop at destroying health facilities that had already been prepared but also had to force health workers in their search for a safe heave to flee these villages in their aggressive search for big towns and could not return any longer knowing the implications of their decision to go back in terms of service delivery and other socio-economic opportunities they face in these big cities. However, committed medical doctors had to flee the country to other places in America and Europe. Some did because of the deplorable condition of the health sector and others because of security. Even after the war, the majority of these doctors who left could not come back, even those who had left on grounds of scholarship. It was evident that succeeding governments could not prioritise health issues in the reconstruction process.

In the middle of this deplorable health situation came the outbreak in 2014 that, within a short period, negatively impacted the health systems in all three countries (Sierra Leone, Liberia and Guinea). Many Sierra Leoneans expected an immediate intervention by the international community on the basis that the immediate involvement with a more responsive and holistic approach by the international community through global health governance initiatives would have stopped the spread at an initial stage. Nevertheless, this was not the case, rather, it was only after the death toll rose to a certain amount and other nationals contracted the disease that it became a matter of global concern, thereby, promoting the late response that was made.

The aim of this study has been to critically assess the WHO and its global health governance initiative impact on the Ebola outbreak in Sierra Leone with a view to identifying the relevance of the initiatives in the fight against epidemics and infectious viruses like Ebola, examining the structures put in place by WHO in its global health governance initiative in not only ending the spread of the virus but also in preventing future outbreaks; assessing the impact created by such a structure during the Ebola outbreak in Sierra Leone; highlighting the challenges faced by WHO in its initiative in ending the outbreak and preventing its spread to other countries considering the obligation owes by the international community in protecting other states from such life-threatening epidemics and finally suggesting ways that will further improve WHO in its Global health governance and its intervention into the health crisis of states in cases of outbreaks like the Ebola Virus Disease.

According to interviews conducted, it became clear that contemporary health risks and opportunities may not just send a clearer and more comprehensive of security taking into account issues around health. Therefore, health-related concerns cannot be solely handled by just states at the national level, considering the proliferation of cross-border and trans-border flows of people, goods and services, and ideas.

From many investigations that have been done, it also became clear that there are many issues outside the health sector that have also been creating daunting challenges for an efficient and effective sector that caters for the majority. Key among these issues have been but not limited to, the following: trade and investment flows, collective violence and conflict, illicit and criminal activity, environmental change and communication technologies.

Irrespective of that fact, many are of the view that there is a desperate need to broaden the public health agenda in a way that captures these globalizing forces highlighted above and to ensure that the protection and promotion of human health is placed higher on other policy agendas. Thus, it is clear, stemming from the current challenges posed, that International Health Governance (IHG) does not sufficiently meet the needs of contemporary health issues.

83% of respondents mentioned "Yes" that the GHG has been very instrumental and relevant in the fight against the epidemic, whilst the other 17% of respondents mentioned 'No' it has posed no relevance. This, however, has shown that GHG has been very relevant in the fight against epidemics, with the Ebola outbreak as a reference point. 20 of them mentioned that GHG serves as a way of dismantling the initial thoughts on issues regarding the promotion of health. That is to say, and it shows the need for many stockholders to start rethinking and addressing factors that, in their view, cross and even ignore the geographical boundaries of states with a focus on preventing and immediately responding to health issues.

20 of these respondents mentioned that GHG stresses the need to define and address the determinants of health from a multi-sectoral perspective. According to them, a global system of health governance begins with the recognition that a broad range of determinants impact on population health including social and natural environments and this has been argued by many scholars

20 respondents stated that GHG is relevant in a way that it indicates the need to involve, both formally and informally, a broader range of actors and interests than just state representation as it was in the case of IHG

The study has also found out that the effort to stop the spread of epidemics and also that of preventing them is not anything new. According to the findings, there has been a lot done to strengthen what has been commonly referred to as global security and among these strides have been the creation of international institutions, and surveillance systems to detect such epidemics that may pose a threat to human survival and the development of vaccines.

60% of respondents mentioned that a structure had been put in place to end the spread of the virus. Other 40% did mention No, that there was not any structure put in place to end the virus.

30% of respondents stated that the measures that were in place to stop the spread of the virus and prevent its reoccurrence have not been too effective. It was evidence, according to respondents, that WHO failed to achieve the "evolution" in global health governance needed in order to ensure that global society is adequately protected against

the multifaceted and increasingly complex nature of modern public health emergencies with specific reference to the Ebola outbreak

60% of respondents confirmed that there has not been no impact created by the GHG structure whilst 40% of them mentioned 'Yes' there had been an impact created so far by this structure.

All respondents who mentioned that there had been an impact created based their contributions on the fact that the Ebola virus did come to an end at the time, and without the intervention of the international community, it would have been impossible for the epidemic to be controlled. On the other hand, those who mentioned no, there has not been any impact tried to explain the weak system that was in place, which further gave rise to the spread of the virus even to other neighboring countries.

Clearly spelt out by the findings of the study was that the capacity of the health systems in Guinea, Liberia and Sierra Leone was limited and challenged with many other issues. Key among these were health practitioners, the basic requirements and requisite tools needed to boom the health sector, ambulances, and the capacity of medical practitioners for such infectious diseases being very low.

In all areas with specific reference to Sierra Leone and Liberia, it became clear to all health stakeholders and the international community that infrastructure, logistics, health information, surveillance, governance and drug supply systems were weak, and this further catered for a more complicated situation especially with porous borders in all these three areas thereby enabling the smuggling of these drugs to other neighbouring countries.

Finally, the challenges faced by the GHG initiative, as discovered, were the following:

Lack of coordination between donor governments NGOs, and recipient countries;

- Confusion of norms and activities due to different ideas regarding health rights and obligations;
- Lack of coordination between WHO, WB, other UNOs and multilateral organizations;
- Lack of national health plans in recipient countries or plans that do not provide for donor coordination;
- Donor neglect of recurrent expenditures;
- Donors' short-term orientation and lack of middle- and long-term commitments;
- Health aid tied to foreign policies of donor or recipient or to purchases of supplies from donor countries; and
- Criteria of "self-reliance" and past performance, channeling aid away from the neediest countries.
- Equitable distribution of drugs and other medical facilities to different areas in the country.

5. Ways forward and suggestions for further study

5.1 Way forward

From the findings of the study, it has been proved that GHG is relevant in an event where the requisite structures exist. It will further improve the concept of the world being a global village where what affects a specific area may have a multiplying effect on other countries if not accurately handled. This importance cannot in any way be underestimated, considering the many activities in other sectors that may have an effect on the health of others if not adequately handled.

The structure that has been put in place, even though very weak, does not have the authority to force member states to comply with recommendations and certain obligations but has created an impact with specific reference to its capability to end the outbreak in the three countries. The structure has not been able to attract a more solid approach and have a central authority but has been existing with the need for more adjustment.

With the Ebola outbreak in Sierra Leone as a case study, it could be ascertained that the fragile structure with a very slow and late response did reluctantly stop the outbreak. Therefore, creating an impact but the requisite things that will help sustain it have, however, been lacking.

With all the impact created, it was evident that the structure faced daunting challenges in many areas that need to be revisited should there exist a more responsive and effective global health governance that will meet contemporary demands. Sponsorship and central authority have been the main challenges that many people believed would positively impact the core aim where they are addressed.

Therefore, the hypothesis initially set has been proved correct that should there have been a prompt intervention by the international community through a well-coordinated approach, the atrocities caused by the Ebola outbreak in Sierra Leone and its neighbouring countries would have been prevented. In addition, it was as a result of the late response that the world experienced one of the deadliest epidemics that killed thousands of people in Africa and a few in the West through their attempts to intervene.

5.2 Suggestions for further study

Based on the findings of the study, the researcher has considered it necessary to proffer the following suggestions.

5.2.1 To the Government of Sierra Leone

1) The government of Sierra Leone should ensure that the condition of service for health practioners is revised in a way that it caters for a more improved system. This will certainly reduce or, as a last resort, stop the movement of health workers from rural areas to urban areas in search of more opportunities. It will also stop medical doctors from ending their profession locally for international contracts and scholastic opportunities without coming back.

2) The government of Sierra Leone should ensure that the capacity of doctors and other medical practitioners is improved in areas of controlling epidemics. This will create a critical mass of medical practitioners who are familiar with different approaches to ending epidemics as and when they erupt. In turn, it will provide assurance from the general policy regarding confidence building.
3) The government, through its development partners, should also ensure that an additional improvement is done relative to infrastructure (medical facilities) currently in the country. The outbreak, among other things, identified the ineffective and archaic health facilities provided in the country. Strategic facilities like holding centers and labs specifically designed to identify risk activities and conduct tests on various preventive tools should be up and running. This will help inform the sector with proactive steps to prevent outbreaks and advise on specific ways to end them where they occur.
4) A strategic national plan that reflects current needs should be prepared and developed by the government. This will enhance the ready-made resources in an event where an epidemic outbreak occurs.
5) The government should also ensure that an effective approach is mainstreamed into other operational plans of the ministry that will ensure an equitable distribution of drugs and other medical facilities within the country. This will make available opportunities according to the needs of the public. This helps in times of outbreak and in also reducing corruption

5.2.2 International Community (WHO)

1. The international community through the WHO should prepare a more coordinated strategy that will enhance the shift response to epidemics in cases where they occur. This will stop the delay that is normally experienced and reduce the blame mostly cast on them, considering the world is a global village, and the introduction of a GHG system requires other states to have a stake in matters of certain countries regarding health.
2. The international community should strategies and introduce a central body through which all interventions in matters of health could be made. The experience got through the Ebola outbreak clearly showed how fragmented interventions in health are made by the international community. This will reduce the duplications of responsibilities and other attempts made in the interventions made by a whole lot of stakeholders with multiple duplications, thereby endangering the situation.
3. The intervention made by the international community in areas of epidemic must be sustained and indications shown of high commitment that will ensure the underlying factors responsible for the outbreak settled. It is observed that most interventions made are short-lived and in many of these, positive and sustainable impacts are not made. Nevertheless, with a sustained approach and high commitment, this problem will be solved.

4. There should also be a unique approach that will inform the institutional normative framework that will guide the system already created in governing health issues. This will ensure the existence of more effective health governance from which all countries in the world may benefit.
5. The international community should also ensure restrictions are reduced as a way of funding third-world countries in areas of developing their health sectors. This is key considering the fact that many rely on funds given.

5.3 Limitations of the study

This study shall limit its scope to assessing the role of the World Health Organization in the prevention of diseases that seem contagious from spreading around the world. The sample of the study was reduced because of the difficulties in getting the health worker to participate in the interview as compared to the relevance of the study, which makes the significant limitations of the study.

Conflict of interest statement
The authors declare no conflicts of interest.

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