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Intergovernmental Cooperation and Universal Healthcare in Sierra Leone:

Can intergovernmental cooperation solve the healthcare fragmentation seen in Sierra Leone following the Ebola Crisis of 2014/15?

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Abbreviations Glossary:

CBPF – Country Based Pooled Funds

CBO – Community Based Organisation

CERF – Central Emergency Relief Fund

CHW – Community Health Worker

CSO – Civil Society Organisation

DALY – Disability Adjusted Life Years

DFID – Department for International Development

EU – European Union

FHCI – Free Health Care Initiative

GAVI – Global Alliance for Vaccinations and Immunizations

GDP – Gross Domestic Product

GFATM – Global Fund against AIDS, TB and Malaria

GOBI – Growth monitoring, Oral rehydration techniques, Breastfeeding, and Immunisation

IASC – Inter-Agency Standing Committee

IMF – International Monetary Fund

MoHS – Ministry of Health and Sanitation

MSF – Médecins Sans Frontières

NGO – Non-Governmental Organisation

NMSA – National Medical Supplies Agency

NPPU – National Pharmaceutical Procurement Unit

OCHA – Organisation for Coordination of Humanitarian Affairs

OECD – Organisation for Economic Cooperation and Development

ORT – Oral Rehydration Therapy

PEPFAR – President's Emergency Plan for AIDS Relief

PPP – Purchasing Power Parity

SACHO – Surgical Assistant Community Health Officers

SDG – Sustainable Development Goals

SLA – Service Level Agreement

SLANGO - Sierra Leone Association of Non-Governmental Organisations

SPHC – Selective Primary Health Care

UHC – Universal Healthcare

USD – United States Dollar

UN – United Nations

UNICEF – United Nations International Children's Fund

UNMEER - UN Mission for Ebola Emergency Response

WHO – World Health Organisation

Abstract

This thesis examines the role of intergovernmental cooperation in aiding Sierra Leone's pursuit of Universal Healthcare in line with the Sustainable Development Goals. To do this, it lays out the situation in Sierra Leone, considering the historical background and the current geographical and political situation. It discusses the healthcare fragmentation present in the country and the reasons leading to this situation, breaking down historical interventions to analyse the role of repeated public health crises. Exacerbated by the international community's lack of cooperation, these interventions have been shown to systematically undermine the already fragmented and under resourced system. Once the situation in Sierra Leone has been explained, the thesis will present an analysis of the barriers towards Universal Healthcare both domestically and internationally. The internal barriers of institutional trust and economic capabilities will have to be addressed simultaneously to the external barriers revolving around poor harmonisation of independent actors. It will consider the previous attempts made historically to coordinate the international actors and the efforts already made in Sierra Leone. Finally, it will discuss whether previous intergovernmental coordination efforts made in different countries for both long term development aid and short term crisis management, hold the key to the defragmentation of Sierra Leone's healthcare on the path towards Universal Healthcare. However, as this thesis will show, perhaps increased intergovernmental coordination in a form similar to the UN's Organisation for Coordination of Humanitarian Affairs will provide the answer for Sierra Leone's Universal Healthcare, but only if states are willing to surrender aid as a tool of foreign policy and if NGOs are happy to cooperate at the loss of their independence.

Introduction

The United Nations (UN) made Universal Healthcare (UHC) one of their Sustainable Development Goals (SDG) back in 2015 under the third goal of "Good Health and Well-being". The goal promotes good physical and mental wellbeing as a human right and stipulates that no one should have to suffer financial hardship when accessing healthcare. After years of civil war and successive crises including the cholera outbreak, the ebola epidemic, and the landslides in 2017, the healthcare system of Sierra Leone became heavily fragmented. It is dependent on foreign aid, and many Sierra Leoneans do not have access to affordable healthcare. The repeated and uncoordinated interventions have systematically undermined national structures and left an incredibly fragmented system that is unable to provide holistic care. Despite the first steps towards universal health coverage with the Free Health Care Initiative (FHCI) in 2010, Sierra Leone is still a long way from the UN's goal of UHC by 2030. Following recent crises worldwide, the international community has made attempts to coordinate and harmonise their interventions with the Organisation for Economic Cooperation and Development (OECD) releasing declarations of cooperation. Alongside this, the UN has begun to use the Organisation for Coordination of Humanitarian Affairs (OCHA) to coordinate emergency responses worldwide. This has been backed up by the development of Country Based Pooled Funds (CBPF), which allow independent actors to collect their funds and operate through one authority. Perhaps these developments in intergovernmental cooperation for emergency aid relief, hold the answers for Sierra Leone's fragmented health care service and could help them achieve the goal of UHC by 2030. This thesis will break down the historical background and attempts made to consider whether intergovernmental cooperation could hold the key to UHC in Sierra Leone.

Methodology

In pursuit of answering the research question regarding intergovernmental cooperation and the path to UHC, this thesis took inspiration from the cooperation progress made in emergency humanitarian relief. Key research terms were used such as: Healthcare Fragmentation, Universal Healthcare, Free Health Care Initiative, SLANGO, OCHA, World Health Organisation, UN, International cooperation efforts, International

coordination efforts, Pooled funding, and Horizontal and Vertical Interventions. From these broad terms, it was possible to keep the search for evidence wide and encompassing before narrowing down and honing the scope of research, focusing the question on intergovernmental coordination through institutions such as the UN. This developed since it quickly transpired that there was a lot of evidence promoting increased coordination and defragmentation of healthcare systems worldwide. Sierra Leone was chosen as the case study as they have been hit by many crises, have a heavily fragmented system, and have previously attempted domestic coordination. In Sierra Leone, the domestic attempt was headed up by the Sierra Leone Association of Non-Governmental Organisations (SLANGO), and to some extent with the FHCI. However, this thesis proposes that perhaps the answer lies at the intergovernmental level, similarly to the UN's OCHA for emergency relief. Papers were prioritised if they were dated after the ebola crisis as this is the most relevant period. The scope of research was kept wide by considering important historical steps that had also taken place, such as the FHCI in 2010. Additionally, it was important to consider the historical context of the international community; what actions had been tried previously and the evolution of thinking that had taken place to lead to the situation that we have today. This thesis predominately used peer reviewed papers, prioritising systematic reviews. This allowed for analysis of a broad range of topics to answer the overriding research question. Since secondary data was exclusively used, a large number of sources had to be included to guarantee that the data was consistent and reliable. Alongside this, interviews of important actors were performed such as the director of CapaCare and various global healthcare practitioners with experience in Sierra Leone. These were undertaken to ensure that the interpretations reflected the practicality of the situation. In addition, public health records and government data were used, alongside data from The World Bank and the World Health Organisation (WHO). Medical data from Sierra Leone is not always up to date or consistent so the most relevant and reliable sources were chosen.

Chapter One - The Situation in Sierra Leone

1.1 - The Background of Sierra Leone

The country of Sierra Leone gets its name from the Portuguese who named the region the Lion's Mountains which was eventually translated into Italian to give the country's name, Sierra Leone (SLANGO, 2020a). The land was colonised at the end of the eighteenth century by freed slaves that had fought on the side of the British in the American War of Independence and labelled "The Province of Freedom"(SLANGO, 2020a). The country was to become a refuge to freed slaves and, in 1787, the settlement of Freetown was established which remains the capital of Sierra Leone today. In 1924, Sierra Leone became a colony under British rule and gained its independence in 1961 (SLANGO, 2020a). However, it soon found itself under a one party republican system that remained in place for seven years. In 1991, the modern Sierra Leone constitution was signed, but the country was plunged into civil war and military dictatorship which saw tens of thousands of Sierra Leonians killed and widespread war crimes committed (MoHS, 2017). The dictatorship was overthrown in 1996 in a coup led by the current president, Julius Maada Bio, and an elected president took over, however, he was ousted in a coup a year later. He was shortly returned to power with the help of an ECOWAS coalition in 1998 and the civil war was declared officially over in 2002 (MoHS, 2017). The civil war caused nearly a million citizens to be displaced and led to the destruction of vital infrastructure and government services. The birth from independence experienced thirty years of destructive turmoil that devasted the country, but it has maintained uninterrupted democracy since 1998. The people have demonstrated a history of activism in their push for independence and the reinstating of democracy, culminating in the Freedom of Information Act introduced in 2013 (EEAS-SEAE, 2018). Despite their active role, the country has continued to be struck by catastrophe after catastrophe with a cholera outbreak in 2012, the unprecedented ebola outbreak in 2014-2015 and the flooding and landslides in 2017 (Keenan, 2017). The cholera outbreak affected thousands and struck a blow to the slowly recovering health services after their newly initiated FHCI in 2010 (WHO, 2012). The ebola outbreak killed nearly four thousand people in Sierra Leone and caused the loss of nearly three hundred of Sierra Leone's incredibly valuable medical staff (MSF, 2015) (MoHS, 2017). During this period, there were an estimated 2,819 deaths from other conditions such as Malaria,

HIV/AIDS, and TB that were neglected due to the crisis (MoHS, 2017). The landslides and flooding caused over 31 million USD of damage and left thousands homeless (WBG, 2017).

In addition to these major crises, Sierra Leone has many deadly endemic diseases such as lassa fever, malaria, HIV, TB, yellow fever, rabies, hepatitis, and other various vector borne diseases. These all contribute to lowering the duration and quality of life of many of Sierra Leone's citizens with malaria, lower respiratory tract infections and diarrhoeal disease ranking in the top five contributors of premature death in 2010 (GBD, 2010). All this affects the burden on the healthcare and the overall GDP and prosperity of the country (CDC, 2020). As is the case in many developed and developing countries, Sierra Leone is also starting to see rises in its noncommunicable diseases creating a demand for another form of healthcare on an already stretched system (Keenan, 2017). Thus, it is of no surprise to see the varying estimates of Sierra Leone's healthcare in comparison to the 191 other UN countries, consistently ranked in the bottom ten, with Sierra Leone ranking 11th last in the WHO UHC index in their 2020 report (WHO, 2020). The country today has a population of around 7.5 million people and the average GDP/capita is 1703 USD a year when adjusted for purchasing power parity (PPP) (WorldBank, 2018a). The most recent data from the World Bank estimates healthcare spending per capita after adjusting for PPP at around 62.40 USD a year with 28 USD per capita paid by the national government (WorldBank, 2017). This figure is estimated to have temporarily risen to 140 USD per capita during the ebola outbreak but on average remains shy of the estimated 86 USD per capita estimated for UHC (Sharples *et al.*, 2015). Since the end of the civil war, Sierra Leone has made a sustained effort to improve the health of the country, spending almost 11% of its GDP on the health budget in stark comparison to their neighbouring countries (WHO, 2018). Due to data and management issues, it is hard to find accurate and up to date statistics on the overall current healthcare situation of the country. However, in 2010, there were around 3.42 healthcare professionals per 10,000 people of the population (WHO, 2010). This number has been estimated to have reduced due to casualties in the ebola epidemic with only 156 native doctors reported in the country in 2016 (MoHS, 2017)(Keenan, 2017). The most recent World Bank estimation of the life expectancy in Sierra Leone was

calculated at 54, ranking it in the lowest five in the world and below the average of 61 for similar demographic countries in Africa (WorldBank, 2018b).

1.2 - Political and Physical Geography of the Country

Sierra Leone is politically divided into three administrative provinces and one area: The Northern Province, Eastern Province, Southern Province, and the significantly smaller, Western Area (Himelein, Isser and Ndione, 2018). The Western Area spans an area of just 557 km2 and has a population of over 1.5 million. This is around 20% of the population of Sierra Leone, with over 1 million citizens living in the capital city, Freetown. In contrast, the Northern Provence is the largest area with nearly 36,000km^2, and a population of over 2.5 million, demonstrating the rural contrast, with only 124,000 citizens in its largest city, Makeni. These provinces are further divided into sixteen districts, each with a representative in Sierra Leone's parliament (Himelein, Isser and Ndione, 2018). Except for the Western Area Urban District that represents Freetown, each district has a distinct elected council with a chairman as representative. Freetown has an elected city council with an elected Mayor. These districts are then further divided into 190 chiefdoms, each supported by an elected local council (Himelein, Isser and Ndione, 2018). The political system of Sierra Leone is a unitary republic that was rated as a Hybrid Regime by the Economist Intelligence Unit, one step up from an authoritarian regime. Currently, the executive branch is held by the Sierra Leone People's Party with Julius Maada Bio as President (Himelein, Isser and Ndione, 2018). He is a retired Sierra Leone general that led the military coup in 1996 to return power to the democratically elected government. However, the All People's Congress hold the majority in Parliament with 68% of the seats in the legislative branch. Except for the iron mines in the Northern Province, the natural wealth of Sierra Leone lies in the Eastern and Southern Provinces (Himelein, Isser and Ndione, 2018). This is in the form of diamond, bauxite, and rutile mines, the latter two are important natural compounds containing aluminium and titanium. Predominantly subsistence farming of rice; agriculture is the largest employer accounting for two thirds of the population and around 42.5% of GDP in 2015 (MoHS, 2016). The physical geography of the country can be seen below in Figure 1.

Figure 1 – Unedited - Map of Sierra Leone showing the administrative divides, including major settlements, and travel infrastructure (2005) (CreativeCommons, 2005)

1.3 – The Ebola Crisis

The ebola crisis was first reported on the 26th of May 2014 in Sierra Leone and was the start of an epidemic that would claim more lives than had ever previously been taken by ebola in the previous forty years since its discovery (Beekman *et al.*, 2015). At the beginning of the outbreak, the response was largely managed by the NGO Médecins Sans Frontières (MSF) and was declared an international public health emergency in August 2014 (MSF, 2015). The ebola outbreak was such a shock to the international psyche that the UN created its first designated health force, the UN Mission for Ebola Emergency Response (UNMEER). Multiple countries led by the UK entered Sierra Leone and began to help to fight the disease, helping to contribute to the near doubling of the healthcare budget per capita (Ross, Welch and Angelides, 2017). When these organisations began to tackle the crisis, they realised the local services were completely inadequate to deal with the scale and severity of the outbreak and began to bypass the existing structures with their own parallel infrastructure. This meant new supply chains, new hospitals, and new clinics that filled the void in the epidemic but undermined the existing infrastructure. In the initial pandemonium, there was very little coordination in efforts and this legacy has left Sierra Leone with over twenty different health care plans, all running side by side, sometimes in ignorance to the others (MoHS, 2017). As the crisis progressed, coordination was eventually promoted by the centralisation of resources under the UNMEER team. However, the national response from the Sierra Leone government was to set up a new task force, separate from the Ministry of Health and Sanitation. This task force took over the Ebola Emergency Operations Centre and created the National Ebola Response Centre with the help of the UK's Department for International Development (DFID), and key members of the British military were embedded in this organisation (Ross, Welch and Angelides, 2017). This essentially created three coordinators: the UN, the UK, and the Sierra Leoneans. Alongside this transition was a shift in emphasis from the Civil Society Organisations (CSOs). CSOs are organisations, created by local volunteers that tackle problems affecting their community. This transition moved them from being pragmatic innovators to being implementors of foreign aid strategies, losing much of their independence and capacity to create grassroot, bottom up solutions (EEAS-SEAE, 2018). Following the crisis, many of the aid organisations with their physical and financial resources left the country

leaving an under resourced system. With the dissolution of the temporary UNMEER in 2015, the project coverages no longer overlapped, and priorities began to change. This process of working side by side, in ignorance of the other programmes, led to further discoordination once the resources began to leave the country and the programmes were either hollowed out or disbanded. The undermining of the CSOs as innovators led to a stagnation in grassroot solutions and helped to swing the motivation for healthcare development back to the international community. This was exacerbated by the Sierra Leone government's reliance on the DFID post ebola strategy as they channelled their resources through NGOs and CSOs, bypassing the national ministries. (Harris and Conteh, 2020). This led to progressive healthcare fragmentation which will be further elaborated in this essay, but this brief case study helps to highlight the fundamental reasons for Sierra Leone's current healthcare situation. The impact of this crisis on the pre-existing national programmes will be further explored in chapter three.

1.4 – Healthcare Fragmentation in Sierra Leone

Healthcare fragmentation is the term used to describe over specialisation and poor coordination when a healthcare system is not run by one overarching authority in contrast to what is seen in developed countries. WHO describes it as "The excessive specialization of health-care providers and the narrow focus of many disease control programmes discourage a holistic approach to the individuals and the families they deal with and do not appreciate the need for continuity in care. Health services for poor and marginalized groups are often highly fragmented and severely under resourced, while development aid often adds to the fragmentation." (Balabanova et al., 2010). Fragmentation is often a symptom of several separate funding mechanisms, with a wide range of services paid from varying and unaligned pools. Thus, it is a broad term that describes poor coordination in the workforce, services, and supply chains and lots of evidence describes how it leads to inefficient use of human and monetary resources (Barr *et al.*, 2019). Healthcare fragmentation goes hand in hand with disharmonised services which lead to duplication of efforts in a resource scarce country and can leave other areas of importance completely neglected. At the same time, it undermines national domestic projects that see their resources and professionals drawn into the international projects. Healthcare fragmentation has become a larger problem

worldwide over the past fifty years due to increased foreign intervention, with proliferation of donors and projects and a simultaneous decrease in publicly owned healthcare facilities. This piece meal approach to healthcare is the opposite of the proposed UHC put forward by the SDGs. In the case of Sierra Leone, it is heavily dependent on foreign aid due to decades of intervention which constitutes around two thirds of overall health spending (Kamara, Xu and Antwi, 2017). This situation is made worse in Sierra Leone due to the number of catastrophes that it has sustained which encourage immediate foreign aid that then leaves when the objective is achieved. This undermines existing structures, leaving the system in a worse state when the foreign organisation leaves, as discussed previously following the ebola crisis (Poate, Balogun and Rothmann, 2008).

Research suggests that these foreign donations distort from the actual healthcare needs of the countries, as donors are likely to ignore epidemiological data in favour of the more glamourous targets (Sridhar, 2009). Examples from other global health projects around the world have demonstrated how programmes for TB, leprosy, and AIDS have often been selected at the expense of more complicated malaria and diarrhoeal disease programmes which bear the higher disease burden (Sridhar, 2009). Following the ebola crisis, a similar development occurred in Sierra Leone and its neighbouring countries with an over emphasis on epidemic preparedness and response, with the neglect of financial affordability and other essential health services (Kolie *et al.*, 2019). Creating crisis response teams for future outbreaks is in the international donors' best interests, even though many other healthcare issues such as childbirth mortality claim considerably more lives with a high mortality of 1360 deaths per 100 000 births in Sierra Leone (Keenan, 2017). This phenomenon occurs for several reasons, including disproportionate media coverage skewing the magnitude of certain issues, and domestic preconceptions formed around ideas of the donor’s own healthcare issues. This was evidenced by the mass hysteria generated by the media towards the ebola outbreak in some countries and exacerbated by individual NGOs campaigning to tackle one issue. A historical example of this comes from Cambodia following the events of the Khmer Rouge. There was an urgent need to address mental health issues following the genocide, but this was not placed as a priority until 2016. One NGO representative

commented on how the domestic stakeholders were aware of the acute need for these services, yet nothing transpired as there was a distinct lack of donor funding (Khan *et al.*, 2017). Although this example is from another country, it helps to demonstrate the effect donors can have on domestic health policy. Additionally, diverging political motivations of different international donors can increase this effect. These targets often fail to address the wider healthcare issues plaguing the country and frequently come with their own criteria and requirements which make it very hard to integrate into the domestic system. Furthermore, they are likely to use their own systems of evaluation and create their own targets making it very hard to combine their resources with other organisations due to a malalignment of goals. When a donor does this, they are unlikely to use pre-existing supply chains and infrastructure as they usually lack the desired capacity therefore, construct their own and bypass national systems (Barr *et al.*, 2019). This concept will be analysed further in chapter three.

Historically, global health initiatives and foreign donations have been project based and focused on narrow targets with defined measurable goals. This type of intervention is labelled as a vertical healthcare intervention; where an objective is made and all resources are focused on this quantitative target (Sridhar and Tamashiro, 2009). An example of a vertical intervention in Sierra Leone took place in February 2020 when the Sierra Leone government announced that 4.6 million mosquito bed nets would be rolled out after a donation of over 13,000 USD from the Global Fund against AIDS, TB and Malaria (GFATM) (Kalokoh, 2020). This initiative is a one-off payment that provides an intervention of mosquito nets against one goal with an easily evaluated outcome of reduced malaria cases. This is defined as a vertical intervention because it is separate from the national healthcare service, likely using its own supply chain to generate the nets and shows no signs of long term sustainability with no nets or net maintenance being provided over the proceeding years. Thus, it is likely that this intervention would be needed again in the future once the nets have fallen into disrepair, however, it remains an easy and satisfying fix to the foreign donor. It is also likely that this boost in provided nets will undermine the pre-existing supply chain by reducing the volume available and by driving up the cost with its increased demand. Vertical interventions are a large contribution to the piecemeal healthcare services that we see in developing

countries and are the reason behind a large proportion of the healthcare fragmentation, standing as a barrier towards UHC in Sierra Leone.

This is in contrast to a horizontal intervention that aims to improve the whole healthcare system by integrating into the current services and producing sustainable outcomes. An example of a horizontal intervention was the creation of the Service Level Agreement (SLA) in Sierra Leone in 2015 (Barr *et al.*, 2019). SLAs allow whole areas of the healthcare system to be taken over by one international or private organisation to increase efficiency and cost effectiveness, in a similar manner to private companies taking on aspects of national healthcare in developed countries (Barr *et al.*, 2019). One area where SLAs have taken over is with surgical care since a report in 2012 estimated that 90% of Sierra Leone's surgical needs were unmet (Capacare, MoHS and NTNU, 2019). In 2012, there were around 24,000 operations performed a year with just under 40% of these being performed by government facilities. An example of an SLA is the Surgical Training Programme headed up by the Implementing Partner CapaCare Masanga who specialise in training Surgical Assistant Community Health Officers (SACHOs) and in 2018, they provided over 8000 operations, demonstrating how they took over a large proportion of that health sector (Capacare, MoHS and NTNU, 2019)(MoHS, 2020b). This SLA has dramatically improved the number of caesarean sections and is dedicated to integrating itself into the healthcare system. This is an example of a horizontal intervention as they are training workers that will continue to work and contribute to Sierra Leone's health service for years after CapaCare ceases to operate. This is further insured as SACHOs are not internationally recognised, reducing the chances of brain drain as fully trained surgeons would be more likely to emigrate. However, these types of interventions require much larger financial resources, sustained motivation, and a large permanent team of healthcare professionals and whilst it remains externally financed, its sustainability is questionable (Sridhar and Tamashiro, 2009). This external financing is also less reliable as an intervention such as CapaCare is much less likely to receive media coverage and will not deliver quick, measurable short term results. Although the introduction of SLAs were designed as a horizontal intervention to improve whole areas of Sierra Leone's health system, they represent the wider problem of healthcare fragmentation. The SLAs are administered centrally

despite the fact they operate in the districts creating a discrepancy between where they are administered and where they are monitored. This creates a scenario where the centre and the districts fail to evaluate, follow up, or regulate the SLAs and this overlapping role of responsibility leads to poor communication (Barr *et al.*, 2019). This subsequent poor communication leads to parallel services provided in the districts and undermines the intent of the SLA as they become a metaphor of the fragmentation in the country.

Horizontal interventions such as these require vast administration processes and are more prone to financial inefficiencies. Previous horizontal attempts in Sierra Leone include the FHCI in 2010 which suffered from financial inefficiencies and failed to reach all its desired targets (Pieterse and Lodge, 2015). This project will be evaluated further in chapter three, but it aimed to provide free health care to mothers and children over five years old, however, it often struggled to prevent hidden charges to a large proportion of its users. Horizontal interventions often have far less successful outcomes due to complicated targets and unforeseen barriers to change. This is caused by the nature of the intervention; attempting to contribute to the whole system and working with the current system, making it harder to achieve goals in contrast to vertical interventions with narrow and easily measured targets. Donors tend towards the creation of targets and quotas to evaluate success which is much harder to achieve in horizontal interventions (Sridhar and Tamashiro, 2009). Vertical interventions were made even more glamourous with the eradication of smallpox and the creation of Disability Adjusted Life Years (DALYs) by the World Bank which demonstrated how much the quality of life had improved from various vertical interventions worldwide (Sridhar and Tamashiro, 2009). Additionally, the Millennium Development Goals further emphasised small vertical targets to improve health everywhere (Sridhar and Tamashiro, 2009). More recently, the international community has once again begun to emphasise the need for horizontal interventions, however, this remains theoretical rather than in practice with more donors still choosing to implement vertical interventions (Sridhar and Tamashiro, 2009)(Sridhar, 2009). Recent examples of vertical interventions include the GFATM, the Global Alliance for Vaccinations and Immunizations (GAVI), and the President's Emergency Plan For AIDS Relief

(PEPFAR) (Balabanova *et al.*, 2010). Thus, while vertical interventions remain popular, the path to healthcare defragmentation and UHC is made much more arduous.

Thus, if parallel solutions are easier to implement and the overall healthcare and DALYs of Sierra Leone are improving, the question arises whether healthcare fragmentation and vertical interventions are an issue. The largest issues raised by healthcare fragmentation is a question of quality of care and sustainability (Barr *et al.*, 2019). The sustainability raises concerns that foreign aid is finite and will eventually be directed to more successful interventions or projects scrapped completely. If Sierra Leone remains dependent on foreign aid, eventually, global willingness to help will begin to diminish or, perhaps the financial means will no longer be available. Financial aid for health began to taper off between 2012 and 2016 and, with domestic healthcare budget cuts globally, the continued flow of money into a foreign healthcare programme is far from certain (Watkins *et al.*, 2018). For this reason, fragmented, parallel programmes are dangerously unsustainable unless they can be successfully integrated into the national system. As discussed above, this fragmentation can be horrifically inefficient with the management of the domestic human and financial capital (Barr *et al.*, 2019). These inefficiencies are likely to frustrate foreign investors over time if they lead to disappointing improvements. These resources would be put to much better use to the benefit of the average Sierra Leonian if they were managed correctly. This includes aligning them to the real problems faced by Sierra Leone and not by misguided foreign perceptions. Additionally, these finite domestic resources are being used up to complete the will of foreign donors and their objectives, in the pursuit of receiving more funding to deal with further foreign agendas. This was demonstrated in the ebola outbreak where national programmes were cancelled as all international aid was directed at dealing with ebola and thus catastrophically undermined existing programmes (Beekman *et al.*, 2015). Finally, is the question of the loss of personnel from national organisations to international agencies. Evidence suggests that foreign aid distorts the market for healthcare workers and can create salary discrepancies and undermine existing domestic structures as the workers move to better working conditions (Barr *et al.*, 2019) A recent example of this was published in a report on wages in the Democratic Republic of Congo; the data is attached in Table I in Appendix A. This demonstrates the large wage

discrepancy between national organisations, various aid agencies, and the UN. It shows how the differences in wages, create a natural selection for the most talented individuals to be taken up by international organisations, undermining the national institutions. A report from DFID backs up these claims and showed how international aid has systematically undermined endemic government programmes and not improved existing capacity (Poate, Balogun and Rothmann, 2008). Despite this report, DFID continues to divert its funds through implementing NGOs (Harris and Conteh, 2020). This trend appears to have developed following the civil war, when the Sierra Leone government lacked the capacity to deal with large scale problems, however, this process was repeated and reinforced following the ebola crisis (Poate, Balogun and Rothmann, 2008)(Harris and Conteh, 2020).

Chapter Two - Barriers to Universal Healthcare

2.1 – Internal Barriers to Universal Healthcare

When the WHO met in Alma Ata in 2016, they emphasised the need for bottom up changes to fix global health challenges worldwide (Kamara, Xu and Antwi, 2017). This stressed the need to end the top down foreign implementation of nonendemic strategies. But in Sierra Leone, there remain challenges to fixing the existing healthcare fragmentation and allowing bottom up solutions to their problems in pursuit of UHC. These can be broken down into internal and external barriers to change with the former broadly categorised into institutional, economic, and social, including trust, motivation, and coordination.

One paper evaluated the institutional limits to Sierra Leone's healthcare system and found that in two of the major districts, the community health centres had an efficiency of around 60% in the use of health resources (Kirigia *et al.*, 2011). This remains a huge barrier to resolving the healthcare fragmentation if foreign aid loses 40% of its efficiency when directed through the national systems further encouraging parallel projects. This adversity to national capacity building will subsequently further undermine the national system and negatively influence their efficiency creating a vicious cycle of fragmentation. Problems surrounding institutional efficiency often coincide with issues of institutional trust. The government has made efforts previously to coordinate foreign aid, however, this has met many barriers due to issues over corruption and inefficient use of resources. To combat this, Sierra Leone has made great strides over the past couple of decades to improve accountability, through the Freedoms of Information Act in 2013 (EEAS-SEAE, 2018). In addition, there are rights and protections under the law for its citizens, however, there are many accounts where these are on paper and not in practice. A Freedom House report commented on how the weak central state could not guarantee basic rights and many powerful individuals were able to evade the law or use it for their own personal gain (Reno, 2010). Ultimately, institutional problems will remain due to a lack of monitoring and effective accounting which allows efficiency issues and institutional trust problems to persist (Moszynski, 2011). Whilst these laws remain in place, they are not followed up and enforced, therefore it will be difficult for Sierra Leone to tackle corruption and hidden charges to

their services. Without monitoring and subsequent enforcement, there will be very little change and Sierra Leone will continue to implement these changes with a large drain on their credibility and resources. This lack of monitoring extends to taxation too, with government taxes being described as optional due to a complete lack of monitoring and follow up which will in turn significantly reduce the government's revenue and ability to fund healthcare services (Balabanova *et al.*, 2010). A report in 2015 calculated a loss of 199 million USD in tax breaks to Sierra Leone's major mining companies, a sum of money around 5% of total GDP (Sharples *et al.*, 2015). This amount of money from just one area of lost tax revenue is nearly half the entire Sierra Leonean healthcare spending. Despite international pressure to improve taxation, this has been met by government resistance as an increase in taxation would jeopardise the ruling party's political position as it would be unpopular to their voting base (Harris and Conteh, 2020).

There are also issues of mistrust with the general public towards the government. They have seen many public health initiatives launched such as the free health care policy for pregnant women in 2002 but, like all that have come previously, they have all slowly failed, creating the expectation that these national institutions will not persist (Bertone and Witter, 2015). This is in comparison to the international aid programmes that are typically more consistent and reliable for the general public. Even with the release of the FHCI in 2010, there have been major issues with costs being reimbursed and, in many cases, the health care is not free at all (Pieterse and Lodge, 2015). This distrust extends towards healthcare generally and was demonstrated during the ebola outbreak which saw Sierra Leonians avoiding healthcare. This mistrust was born out of fear from being separated from their families, not being allowed their burial rights and the overall fear from the high mortality of the disease which saw many of their friends and family die in isolation in healthcare facilities. This mistrust became so extreme that in Guinea, the neighbouring country to Sierra Leone, eight members of an ebola awareness team were murdered as they were suspected of deliberately spreading the disease by the villagers (Roache *et al.*, 2014). This mistrust reduces the capacity for the average public to get involved in improving their healthcare and further places an emphasis on the need for education and reform (Hakhverdian and Mayne, 2012).

These institutional barriers contribute towards and are perpetuated by the limited infrastructure. Around 70% of Sierra Leone's population lives in rural environments while 70% of the healthcare provided is in urban environments. A survey in 2008 demonstrated how 90% of surgeons and surgical care were concentrated in the capital city, Freetown. (Kingham *et al.*, 2009) This disparity is intensified by the lack of transport infrastructure, limiting the ability and increasing the cost of accessing medical facilities (Witter *et al.*, 2018). The lack of infrastructure and dispersed populations make these jobs highly unattractive and problems persist for staff retention and ghost workers, where staff are on the pay role but not working.

The healthcare budgets all coincide with the overall economic state of Sierra Leone. The country already spends over 10% of its GDP which equates to around 400 million USD (WHO, 2018). With such a limited healthcare budget in relation to its population, the options for improving their healthcare provisions are limited. These economic decisions are further limited by the instability of Sierra Leone's commodity based economy which is orientated around ore exports and diamonds which are susceptible to market fluctuations. This places CSOs in a position where their financial foundations are weak which means that they must orientate themselves towards foreign funds. This prevents them from evolving to local needs as they have to meet broad criteria to be eligible for a collection of different funding pools. This leads to services relying on fluctuating donor demands and priorities. These economic restrictions come with issues of wages and quality of the workplace which can lead to problems with healthcare worker retention. The number of healthcare workers per 10,000 of the population is very low despite large training schemes and this is because the working conditions of foreign aid can be remarkably better than domestic services and do not keep up with changing costs of living (Wurie, Samai and Witter, 2016). Wages, working conditions, hours due to staff shortages and financial strains due to travel and rurality of work can all lead staff to choose NGOs which in general account for these issues because not doing so would be unethical (Wurie, Samai and Witter, 2016). An example of the wage disparity is shown in Table I in Appendix A that demonstrates the dramatically higher wages from foreign organisations. These issues would require a large concerted effort in order to overcome them as they cannot be tackled individually. They require greater

education, communication, reform for improved taxation, transparency, monitoring, decentralisation and larger ownership by Sierra Leone. These barriers to change represent deep, entrenched obstacles to the required change necessary in Sierra Leone that must be addressed in one sustained effort. These barriers will be discussed in greater depth throughout this thesis.

2.2 – External Barriers to Universal Healthcare

Alongside these internal barriers to change, exist multiple external barriers that are created by the international aid model that operates in countries around the world. These are broadly caused by aid conditionality, the motivations of international aid, and the characteristics of NGOs. Aid conditionality is when terms, usually regarding the recipient country's domestic policy or foreign policy, are attached to aid before the recipient can receive the funds and it remains a hotly debated topic for both its effectiveness and its morality. It has historically been used to pressure countries into becoming more liberal and to support human rights, however, it has also been used by countries to push their own agendas. Traditionally, varying forms of aid conditionality have been the answer to attempt to keep the national government invested in their health programmes. Evidence suggests that foreign aid directly influences governmental policy, and with multifarious donors, national policy can be pulled in multiple inconsistent directions away from the indigenous path of development (Uh and Siddiky, 2017). However, the concept of aid conditionality is not homogenous. Some countries use aid flows as part of their foreign policy tool kit to pursue their own national interests. This can be in various forms, but one technique of aid conditionality is called Tied Aid. This strategy was used in Europe with the Marshall Plan where the United States provided development aid, and in return, the Europeans had to use that money to buy American products. Tied aid is still used today in the developing world, however, it often leads to these countries purchasing goods that could be purchased for a much cheaper price elsewhere, reducing the efficiency of the provided aid (Uh and Siddiky, 2017). Following the Paris declaration by OECD countries, 92% of OECD aid to Sierra Leone was untied from 68% the year before in 2005. Overall, 75% of aid from all donors was untied in 2006 (OECD, 2010). Aid conditionality was also used by the Bretton Woods institutions which famously implemented their neoliberal aid

conditionality. Aid from The World Bank and the International Monetary Fund (IMF) was contingent on recipient countries changing their political and economic models to the accepted neoliberal approach. This push was because the economic community agreed that the neoliberal economic model was the best way out of poverty for these countries. This included democratisation, liberalisation of the markets and free trade, and the privatisation of national industries (Pandey, 2018). However, this move to privatisation and reduction in tariffs left many of the developing nations unable to pay for their public health systems. These institutions also used aid to impose austerity measures on these countries to contribute towards their debt payments. Parallel to state sponsored aid, foreign private donations equally distort the healthcare market. Many foreign donors will have their own previously conceived ideas of what needs to be done to optimise their donations and what areas of health need to be tackled. This can lead to multiple diverging conditions of aid that pull the domestic policy of countries in conflicting and confused directions (Uh and Siddiky, 2017).

One source discussed the aid dependency of some African states and described it as the means for control and domination over developing countries (Degnbol-Martinussen and Engberg-Pederson, 2003). If this harsh analysis is true, it remains to be seen whether this external control is positive, created by the liberal world order, or a distracting and diverging political influence that forms a barrier to change. In cases where there is no political will to implement positive changes, external pressure to do so is a force for good. However, this is ethically questionable and would only work if the external pressure is coherent and coordinated which it is often not (Kanbur, 2000). Furthermore, these aid agencies are unelected bodies that try to influence these countries in opposition to democratic liberal self-determination. Due to a lack of coordination in the international aid community, there is not one single voice that communicates with these countries and supports their national strategy. This strategy would only be effective if there was an evidenced based solution for successful aid, but as shown by the introduction of the neoliberal ideology, there does not appear to be an easy answer. Due to this lack of coordination,#the recipient governments are also capable of playing the donors off each other due to the competitive nature of the aid scene (Harris and Conteh, 2020). This further reduces the effectiveness of any aid conditionality and makes its

evaluation harder. This failed coordination allows them to cherry-pick their reforms amongst all of the donors (Balabanova *et al.*, 2010). In the scenario where the recipient country is reluctant to change, questions remain whether external pressure from foreign aid can cause actual meaningful change. This is initially argued by the Samaritan's Dilemma, where the aid provider is seen as the 'Samaritan'. This principle argues that the 'Samaritan' wants to give aid so is reluctant to implement restrictions if the recipient government revokes on its promises, especially as it will affect the poor before undermining the government (Kanbur, 2000). This coincides with the international community's SDGs which attach a clear agenda. This weakens the donor's bargaining power as they have a clear goal to achieve. This shows the inherent weakness in the power dynamic between the donor and recipient. The short leash created by aid conditionality pulls the donor and recipient alike. In some cases of aid conditionality, aid is provided to the poor on the pretext that the national government matches the funding. If the national government funding falls, the donor should also cut their funds, but this would result in the poor losing out on twice the amount of funding, and in the case of healthcare, will lead to deaths. In the cases where aid conditionality leads to reform, it can often be mock compliance where it is ignored once the aid is received and the leverage is lost (Kanbur, 2000). This also raises the credibility of the reforms that do stay in place, as aid often props up political parties that want change. However, if the aid stops, these parties can lose their credibility leading to the reversal of the policy change and demonstrating the unsustainability of the idea. Alternatively, aid providers can use their aid to influence local leaders and DFID were even accused of using their aid flows to force regime change in Sierra Leone (Harris and Conteh, 2020).

In the case of Sierra Leone, where there is arguably a political will to implement change, conditional aid can dilute this and distract from a common domestic strategy. This can lead to distracted priorities and contribute towards the healthcare fragmentation seen in Sierra Leone. This is exacerbated by the large volume of time and administration required to negotiate with, organise and report back to the aid agencies by the national government with some estimates calculating 30-40% of project funds being used in this pursuit (Balabanova *et al.*, 2010)(Kanbur, 2000). Though the overall level of aid to countries over the years has remained relatively stable, one report showed

how the increasing number of donors led to thousands of reports and evaluations forcing some governments to have annual holidays from donor meetings (Balabanova *et al.*, 2010). This equals a large amount of national political will, time, and energy being used jumping through foreign hoops instead of addressing national issues and consensus building (Kanbur, 2000). Overall, it remains unclear whether aid conditionality is an effective force for good or a barrier to change (Uh and Siddiky, 2017). But it does question the ethicality and effectiveness of a foreign imposed strategy and whether the resources could be used more effectively in a country that is demonstrating a desire to improve their health system. This supports the idea that perhaps the international focus should be taken away from the quantity of aid provided and drawn towards the quality of aid and the partnerships created.

Finally, comes the issues of NGOs themselves. This does not aim to devalue the lifesaving work that NGOs perform around the world but aims to objectively evaluate the effectiveness and unintended consequences of the services that they provide. The first NGOs to be created were a result of emergency relief and humanitarian assistance and many self-proclaim that their initial intention was to exist for a couple of years and to outlive their usefulness to the country (Uh and Siddiky, 2017). However, years later, many of these NGOs still exist and are much bigger and thoroughly integrated into the communities that they work with. Most find that they have not outlived their utility and in understandable contradiction, seek to expand and do more to help the people they work with. Many NGOs have changed name and form over the years in response to catastrophes and changing demands, often taking on more and more responsibilities once the crisis has passed demonstrating a deft ability to adapt to changing environments. These core characteristics are part of what makes NGOs so effective in the communities they serve and help to explain why they have persisted much longer than their planned lifespan.

Alongside these core characteristics, many NGOs pride themselves on their financial and political independence. This makes these NGOs very effective at working against oppressive governments for the greater humanitarian good. However, in scenarios where the government is looking to create meaningful improvements and seeks to

coordinate the efforts of these NGOs, it can create friction as these coordination attempts ultimately infringe on their proud independence. This characteristic has arguably put NGOs in Sierra Leone in conflict with the government's attempt to coordinate them (Kaye and Forst, 2018). It stands as a barrier to international cooperation in aid, especially in circumstances of aid conditionality where it could be in the best interests to withhold the humanitarian aid in the pursuit of causing political change, but at the risk of the lives of the poor. This undermines the bargaining power of conditional aid, albeit for sound ethical reasoning, but perhaps reduced foresight. Furthermore, the sheer number of NGOs further reduces the political bargaining power of actors as they can be undermined by any of the other actors who seek to fill unmet needs. At the end of the day, NGOs and donors want to give aid. If NGOs implement strict aid conditionality, donors may look elsewhere to other NGOs that will provide the desired services. This means that NGOs would lose out twice by punishing the domestic government for their infringement on the terms. The NGOs' staff and projects require the continuous flow of aid and implementing sanctions via aid conditionality impedes this process and jeopardises their plans and livelihoods (Kanbur, 2000). Furthermore, by providing the vital services, foreign aid and NGOs remove the responsibility of the national government to organise an equivalent service as there is no political pressure created by the service void further reducing central motivation to change. If these services are of a higher quality than the national services then this creates a natural selection towards the free, high quality, and reliable foreign service. This damages the reputation of the national service and further exacerbates the other barriers to change, encouraging increasing fragmentation.

These comments do not just relate to NGOs. When states act as donors, they too value their financial and political independence. States are capable of influencing recipient states and can use aid as a tool of foreign policy. Additionally, many states also wish to provide aid as there is an expectation from their citizens. One diplomat commented on the thinly veiled threats from one Sierra Leone minister to a DFID diplomat, commenting on how the British tabloid, The Daily Mail, would react when children start dying (Harris and Conteh, 2020). This places state donors into a similar bracket as

the NGOs that value their independence and are also susceptible to the Samaritan's Dilemma.

Chapter Three – Efforts Made to Improve Healthcare

3.1 – History of International Efforts

The debate on how to provide humanitarian aid and surmount the barriers to change has been going on for decades. Discussions on UHC for all were held at the renowned WHO conference of Alma-Ata in 1978 where famous priorities and goals were set. The first principle of the Alma-Ata declaration was that physical, mental, and social wellbeing should be a human right and the obligation of a government to provide (WHO, 1978). It was decided that the best way to achieve that by 2000 was to promote primary healthcare in the form of UHC worldwide. However, it went wider than just providing health and included many of the development goals we have today such as education, food supply and nutrition, water and basic sanitation. They also addressed additional efforts in economic sectors such as animal husbandry, industry and communications (WHO, 1978). Evidently, these plans were incredibly holistic and a clear horizontal intervention. Furthermore, the emphasis for the change was placed on the national governments with "All governments should formulate national policies, strategies and plans of action…" and the quantity of aid was ignored over quality "…to use available external resources rationally." (WHO, 1978). And finally, it stressed the importance of the international community, the international organisations and other NGOs and multilateral/bilateral organisations to work together on this common goal and to channel the increased technical and financial support needed to make it happen. However, these goals of a horizontal, holistic, and coordinated international intervention for UHC worldwide by 2000 were quickly labelled as idealistic by members of the aid community. The Rockefeller family sponsored a conference in Bellagio, Italy just one year after and based their conference on the paper "Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries" (SPHC) (Walsh and Warren, 1979). This paper essentially highlighted the greatest burdens of disease in developing countries and aimed to provide low cost targets to start with as a transition towards primary healthcare for all. Although which diseases should be targeted was initially unclear, it quickly transformed into the GOBI plan with four vertical interventions: Growth monitoring, Oral rehydration techniques (ORT), Breastfeeding, and Immunisation (Wisner, 1988). Growth monitoring is important for spotting malnutrition early and tackling any undiagnosed diseases. ORT is used in the treatment

of diarrhoeal disease which is the fifth leading cause of premature death in Sierra Leone. Breastfeeding advice is vital for the prevention of HIV transmission, and to promote breastfeeding over bottle feeding where possible, to help with the child's immunity and growth, and the reduction in waterborne disease transmission. The vaccination programmes help to tackle some of the endemic diseases of a country to generate herd immunity and hopefully eradicate certain diseases one day. This plan was chosen as it loosely followed the suggestions of the Alma-Ata declaration whilst being specific and targeted enough to provide easily achievable goals. These were later expanded upon to three more vertical interventions: food supplementation, female literacy, and family planning, and became known as GOBI-FFF (Wisner, 1988). This strategy was offered as an alternative to the Alma-Ata conference as it provided targets, strategies, and showed how it would be financed in contrast to the declaration. However, it demonstrates that from the dawn of the universal health coverage plan, it was attempted via vertical intervention aid with disharmonised coordination. One author went as far as to suggest that SPHC was not an alternative to UHC, but a counter revolution that undermined and threatened coordinated action (Newell, 1988).

In the 1980s, the neoliberal economic idea emerged and was embraced by the developed world. At this point, the international institutions of the IMF and The World Bank were used to impose austerity measures on the debt stricken developing nations (Pandey, 2018). Loans were provided on the priority of privatisation and free market economies causing government cuts to many of the pre-existing social services and healthcare. During this period, public owned health systems were underfunded and under resourced, and eventually, user fees were introduced making healthcare even less accessible to those that needed it the most (Pandey, 2018). In their place, the piecemeal international vertical strategy took over such as GOBI-FFF and with that, the idea of a UHC system by 2000 died. The absence of any functioning public health service became particularly noticeable to the west during times of crisis and was highlighted in the AIDS epidemic, influenza outbreaks, and the ebola epidemic of 2014/2015 (Pandey, 2018). Mounting a response to these crises was difficult, resource intensive, and incredibly expensive due to the lack of native capacity.

In 2005, the OECD convened in Paris and formulated its own declaration for aid, orientated around five principles: ownership, alignment, harmonisation, results, and mutual accountability (OECD, 2008). This represented a shift away from the SPHC, placing the plans in the hands of the national government, aligning it with current programmes and not imposing their own agenda whilst forging a partnership that works together for an agreed upon, common goal. This represents a marked step back towards the declaration of Alma-Ata in 1978. Alongside this, the emphasis from the WHO towards UHC had changed from the arguably idealistic view of the original declaration to the achievable goal that no one shall have to suffer financial hardship to access healthcare around the world (WHOE, 2018). This shift, though subtle, is important as the lack of financial planning was one of Alma-Ata's greatest weaknesses and opened it up to the largest amount of criticism from the international aid community. This declaration was followed up by the Accra declaration in 2008 and the Busan declaration in 2011 and these represented a shift to even more ownership from the part of the aid recipient and an enhanced emphasis on cooperation and harmonisation of both the international community and the national system (OECD, 2008). By 2015, the members of the United Nations signed the 2030 Agenda for Sustainable Development and the seventeen SDGs which, included within the third goal, is a return to the idea of UHC for all with the added caveat of no financial burden to the user (WHOE, 2018).

3.2 – Efforts made in Sierra Leone

With this historical background, several key efforts have been made in Sierra Leone to combat the healthcare fragmentation seen since the end of the civil war in 2002. These are the creation of SLANGO and the formation of the FHCI. SLANGO was created in 1994 when there was a proliferation of NGOs entering the country because of the civil war and due to an international increase in NGOs (ICNL, 2009). As a national organisation, their goal was to coordinate the efforts of both international and domestic NGOs and to form communication links between the NGOs and the government. SLANGO operates with five main objectives: "To integrate NGO efforts more effectively into national development", "To develop a framework within which NGO can collaborate with and reinforce each other's activities more effectively.", "To promote coordination, networking and harmonization of NGO activities in Sierra

Leone.", "To facilitate and sustain the growth of NGO activities in Sierra Leone through providing advisory services, training, research opportunities and other facilities", and "To liaise with government department and/or ministries responsible for NGO activities" (SLANGO, 2020b). These objectives address a lot of the issues caused by vertical interventions and would significantly improve the healthcare fragmentation described previously. However, alongside these goals, NGOs have to follow certain rules to be able to operate in the country and this includes compulsory registration to SLANGO every two years with administration fees to be covered by the NGOs (ICNL, 2009). In addition, NGOs, CSOs, and Community Based Organisations (CBOs) have to meet certain requirements to be defined as such under the SLANGO definitions of these organisations and each of these have subsequent different rights (ICNL, 2009). Finally, SLANGO requires financial coordination, so all spending has to be run by SLANGO with all asset purchases becoming the property of Sierra Leone and not the NGO (ICNL, 2009). In addition, NGOs have to spend at least 70% of their budget directly on their target group reducing the amount that can be spent on administration (ICNL, 2009). In return for this, SLANGO is supposed to organise monthly sectoral meetings to address specific common issues and also quarterly general meetings to discuss and orientate the country's programmes in a common, harmonised direction (ICNL, 2009). However, a large amount of healthcare fragmentation exists and unsurprisingly, SLANGO has received widespread amounts of criticism with the European Union (EU) commenting "…there is very little evidence of strategic planning, annual budgeting and financial control. This lack of organisation is limited by resource, both financial and human, scarcity. Coordination is also very weak, hampered by the competition for funds, and SLANGO, does not fulfil its mission to coordinate the activities of its member NGO…" (EEAS-SEAE, 2018).

SLANGOs objectives have come under international scrutiny for impinging on international law and the right to association. In a letter addressed to the government of Sierra Leone, NGOs raised criticism over several points. Firstly, they were concerned that forced alignment to the government's policies would restrict the scope of activities and jeopardise their independence (Kaye and Forst, 2018). This lack of independence and obligatory subscription to SLANGO makes it extremely difficult for NGOs and

CSOs to operate as critiques of the government and be open and honest counterweights to their policies (Kaye and Forst, 2018). They further disagreed with the narrow definitions of NGO, CBO, and CSO and the differences in special treatments that they received arguing that these administration hurdles could be enough to extinguish small grass root ideas (Kaye and Forst, 2018). Furthermore, these administrative financial burdens could be too large for grass root ideas to evolve and become legitimised. Thus, this impedes on international law to the right to association since these organisations are only legitimised if they subscribe to SLANGO (Kaye and Forst, 2018). The budget requirements held by SLANGO, where 70% of the funding has to be spent on the target group, arguably further reduces the scope of activities that can be undertaken as some are administratively or practically difficult to implement; making NGOs more likely to take on easier, more superficial interventions such as vertical interventions (Kaye and Forst, 2018).

The FHCI was released in 2010 for pregnant women, lactating mothers, and children under five and was the country's third attempt at free healthcare. The programme attempted to address seven areas of development that reflect the healthcare fragmentation and the previously discussed barriers to UHC. These include the drug supply chain, health workforce, governance, infrastructure, communication, monitoring and evaluation, and financing (Witter *et al.*, 2018). The initiative was aimed at targeting the SDGs of improved maternal mortality and under five's mortality in the eventual pursuit of UHC. This represents an attempt to simultaneously correct and navigate some of the barriers to change presented in chapter two meaning that a successful FHCI would represent a great step towards UHC. One of the first issues to be addressed was the issue of salaries and brain drain. Previously, wages were incredibly low and failed to keep up with the increases in costs of living. Doctors and nurses received around 200 USD and 100 USD a month respectively which was so low that they were often forced to charge for free healthcare provisions in order to top up their wages (Donnelly, 2011). This was the first issue to be addressed in part by the health worker strikes before the initiative began, making the government's position appear fragile. The government decided that the wage increase and future wages would be covered by the public budget

which resulted in a subsequent spike in foreign aid due to the clear sign of commitment and ownership from Sierra Leone (Donnelly, 2011).

All staff saw an increase in wages, and despite critics arguing it was a delayed increase that did not keep up with the cost of living changes, doctors were now incredibly well paid. The pay rise was so significant that wages rose from consisting of 26% of the budget to 60%. Because of this increase in wages, there was a large shift to capital purchases from foreign aid, estimated at 95% of all capital being paid for with foreign money arguably making these reforms relatively sustainable, as wages are the long term commitment in comparison to a one time capital investment (Brikci and Sophie, 2016). In addition, the system moved to a performance based weighting to the employees' wages to encourage greater efficiency from staff (MoHS, 2017). What is still lacking though is a process to close underutilised and underperforming services. The most recent payroll cleanse in 2015 demonstrated nearly one hundred facilities with zero staff on the official payroll (MoHS, 2017). These staff are usually unpaid volunteers who are likely to charge for services and provisions. Despite the government covering wages, the entire initiative is estimated to be funded somewhere between 60-80% by foreign aid, with DFID contributing 40-55% of the budget (Witter *et al.*, 2018). This means that the FHCI is only sustainable in the short term if donor interests can be maintained. Fiscal analysis suggests that the initiative could run a short fall of 66 million USD by 2025 which would require an increase in spending of 12.5%, equating to around 1.6% more of GDP (Witter *et al.*, 2018). This short fall could be decreased by efficiency gains from returns of scale and new taxes but, for the meanwhile, is completely dependent on foreign aid, thus, if donations stop, all gains are likely to be lost. A report from the WHO pessimistically claimed that, even if Sierra Leone can reach its promised goal of 15% of GDP being spent on health, it would not be able to cover all costs for the FHCI (Thompson, 2010). Furthermore, this all relies on Sierra Leone's commodity based economy which is susceptible to market fluctuations and subsequently took a hit during the ebola crisis, losing 14.9% of its GDP in just the first year of the epidemic (Kum, Olayiwola and Aloysius, 2019). On the other hand, the developing countries such as Sierra Leone are forecasted to see large growth over the next couple of decades which would only be accelerated by UHC (WorldBank, 2020). Forecasts suggest that

healthcare spending will have to increase faster than GDP, but UHC has been theorised to be good for economic growth since it means individuals have more means and are more likely to access education (Harris and Conteh, 2020). This can affect population growth and GDP per capita and help a country to escape the poverty trap. If an effective system can be put in place that has surmounted the barriers to change, then it would provide a powerful platform for Sierra Leone to take ownership of one day. The funding for all of this was maintained by individual donors such as DFID, GFATM, and The World Bank and, although some of this was channelled directly through the government, represents a fragmentation in the financing (Brikci and Sophie, 2016). By not forming one common funding pool, these organisations maintain their political sovereignty but jeopardise the harmonisation of their efforts. The Lancet review evaluated that a 10% increase in pooled funding, corresponds with a 1.4% increase in the UHC index so offers a path to defragmentation and UHC in Sierra Leone (Dieleman *et al.*, 2018).

Despite its narrow target focus and fragmented funding, the FHCI is a horizontal intervention as it is attempting to address much wider healthcare insufficiencies rather than reaching fixed vertical goals. It is a national strategy that has been supported by the international community so represents a much higher level of sustainability and ownership. As with a lot of horizontal interventions, maintaining donor interest is not always easy as it is much harder to measure outcomes of your investments. This is potentially undermined by multiple sources describing how many women end up having to pay for the "free healthcare" due to a lack of accountability from staff who subsequently charge for the free drugs (Pieterse and Lodge, 2015). This demonstrates one of the reasons why foreign aid is reluctant to engage with national services if they are likely to see their investments diminished by corruption. In fact, the head of MSF in Sierra Leone, Stuart Zimble said "the challenge now is to maintain donor interest… If the donor funding falls out too quickly, we will see a train wreck…" (Thompson, 2010). This demonstrates the lack of political pressure the international community can put on Sierra Leone's government for change as they are completely invested in the FHCI being a success. Fortunately, in the case of Sierra Leone, the government appears to be equally committed, dedicating large amounts of their budget to salaries. If the

international community loses interest, they will be left with a large payroll but with no equipment to function. Fortunately, the month following initiation of the FHCI, double the amount of children sought healthcare and there was a threefold increase in malaria treatments (Donnelly, 2011). This kind of public demand is likely to maintain donor interest.

During the ebola crisis, the FHCI took a major hit as it was unable to respond to the demands of the situation. Because of this, it was subverted by many NGOs that were sent in to deal with the problem undermining the initiative further. In 2010, Sierra Leone was receiving 458 million USD of aid, but this increased to 946 million USD during the crisis (OECD, 2017). This was all necessary to stop the spread of the disease, but it catastrophically damaged the national services as discussed in chapter one due to the vertical nature and parallel programmes that undermined existing services. It is estimated that Sierra Leone lost between 6.85%-10% of its healthcare staff and pre-existing problems such as the drug supply chain were worsened (Kahn *et al.*, 2019). Utilisation of the service had fallen by 23% in 2017 and many reviews describe the health care as costly, unreachable, and poor quality, with huge disparities existing between rural and urban areas (Elston *et al.*, 2019). Due to this, many of the gains seen at the beginning of the initiative to maternal health, under five mortality, and communications have been undone by ebola and the consequential international intervention. Additionally, following the outbreak, many interests of foreign aid had changed meaning that funding was directed in different avenues, namely in public health, epidemiology, and crisis management to prevent further outbreaks of the disease. Despite this, the FHCI demonstrates a national will and motivation to change but demonstrates how the country is hampered by many barriers that make foreign aid unattractive and unsustainable.

Following the ebola crisis, DFID became the lead aid agency in Sierra Leone after the UK's large response during the outbreak (Harris and Conteh, 2020). The relationship between these two was so close that the phrase "Papa don cam fo save pikin", meaning "Father has returned to save his children" was uncomfortably used to refer mostly to the UK, Sierra Leone relationship (Harris and Conteh, 2020). Because of this intimate

relationship during the crisis, it was their strategy for post ebola recovery that was chosen by the national government. DFIDs argument was to strike while the iron was hot and push through as much reform as possible, but the heavy handedness was refuted by many of the other donors, some of which refused to get in line with the national recovery strategy. Together, they formed the President's recovery priorities which included: restoring basic services, restoring the FHCI through the Community Health Worker (CHW) programme and supply chain reform, and improved sanitation nationwide (MoHS, 2020a). The CHW programme and supply chain reforms represent two perfect examples of recent healthcare fragmentation. The CHW programme was created by the international community in 2012 to meet rural health care needs but was revamped following the ebola outbreak (Barr *et al.*, 2019). Pioneered by DFID, who prefer to channel their resources through NGOs rather than directly through government branches, the CHW intervention exists almost completely separately to the other national and international programmes. This programme was initially intended to be a horizontal implementation and improve the whole system's healthcare by introducing trained primary care staff. However, its early roots were established by vertical interventions led by NGOs on international grants and these have left their legacies till today. The whole programme runs externally to the Sierra Leone healthcare budget and relies entirely on the international support for financial, technical, and operational aid. Because it runs externally, it is often in ignorance of many other foreign aid programmes operating in the country and currently shows no demonstration of long term sustainability (Barr *et al.*, 2019). In addition, this plan is being implemented by DFID and foreign donors and is not supported by the whole community leading to a lack of coordination amongst aid providers (Harris and Conteh, 2020). There are plans to integrate this into Sierra Leone's governmental structure, but it is due to be taken over by a different department to the Ministry of Health and Sanitation further demonstrating how the domestic structure is adjusting to the demands placed on them by foreign donors (Barr *et al.*, 2019).

As this paper has previously discussed, the repeated vertical interventions and healthcare fragmentation are in a vicious cycle with parallel programmes and parallel supply chains. These parallel supply chains are often complicated and create

inefficiencies and price distortions that undermine the national system. A report in 2011 by UNICEF estimated 26% of drugs did not reach their destination due to infrastructure problems and staffing issues (Maxmen, 2013). This loss of 26% efficacy is only going to further deter external interest and provide more motivation to establish parallel supply chains. Supported by DFID, USAID, GFATM, The World Bank, and UNICEF, the construction of the National Pharmaceutical Procurement Unit (NPPU) was created to support the foundation of the FHCI in 2012. However, a lack of financing and government support prevented the institution from moving forward. This was reconsidered in 2016 due to the critical nature of a functioning national supply chain to the sustainability of any healthcare intervention. The project was relaunched as the National Medical Supplies Agency (NMSA) which adopted the NPPU mandate. This was supported by an Act of Parliament in 2017 and an initial two year plan to get the operation started (MoHS, 2017). Despite reform, there remain persistent parallel supply chains that exist for the large international vertical interventions on HIV, TB, malaria, nutrition, and the neglected tropical diseases which is not surprising when you consider the international organisations that supported its creation. The final mandate of the NMSA is to take over the whole medical supply chain for the country, but these programmes have been protected, likely as they are part of the global fight for the SDGs (Barr *et al.*, 2019). Unfortunately, the supply chain issues were worsened by the ebola outbreak in 2014 and the landslides in 2017. A fully strengthened supply chain service would be a great step towards healthcare harmonisation, aid cooperation, and a move towards UHC by 2030 in line with the SDGs. The Strengthening of the NMSA will require coordination from all the international actors in order to prevent further fragmentation and undermining of the reform. This support will be required to develop the reliability and credibility of the NMSA and help to overcome other barriers to change such as institutional trust. As DFID was leading these reforms, it was noted how other key actors did not support the decisions and continued to act independently. As mentioned, DFID had created its own implementing team of NGOs and worked externally to the ministries. Meanwhile, UNICEF had adopted the opposite strategy and was working exclusively with the ministries whilst the EU was described as following long term goals, with rigid and unadaptable programmes that were disconnected from the day to day realities of Sierra Leone and DFID's strategy (Harris and Conteh, 2020).

Chapter Four - Can Intergovernmental cooperation help Sierra Leone towards Universal Healthcare?

4.1 - The History of Intergovernmental Cooperation

The international community has seen fluctuating enthusiasm for greater aid coordination since the Alma-Ata conference in the late 70s. These calls have seen varying attempts to find a solution and perhaps some of these attempts hold the answer to the healthcare fragmentation in Sierra Leone, in pursuit of UHC. The Paris Declaration by the OECD recognised five areas for improvement, focused on ownership, alignment, harmonisation, results, and mutual accountability as discussed previously (OECD, 2008). Ownership describes how the onus for development and humanitarian aid must come from the domestic level. Developing countries should set their own strategies to reduce poverty, improve their healthcare, and generate reform to tackle their institutional insufficiencies and corruption. This is highly important because it refutes the neo-colonialist ideologies, but also questions the significance of any change if it does not have the will and political pride of the people behind it. Historically, this has often been diluted due to disharmonised aid conditionality and frequently, the domestic spark for reform has not been nurtured by the international community. Alignment describes how donors should align behind this domestic strategy and use local systems to help reach these goals, rather than creating their own goals and objectives. Currently, with multiple international actors, individual action plans are agreed with the national government, but these action plans are often misaligned with the different actors. This brings up the issue of harmonisation, which simply states that donors should work together, sharing information, resources, and working to improve procedures and mutual evaluation. This would significantly reduce the fragmentation seen in Sierra Leone as actors would become aware of all the other projects and procedures, reducing duplication, and increasing efficiency. The focus on results is necessary as it allows donors to monitor their interventions. Although historically, this had tended towards the implementation of vertical interventions, horizontal interventions still produce measurable results, but these would have to be harmonised and comparable between all of the actors involved, with an understanding of the long term nature of the project. Finally, mutual accountability describes how donors,

partners, and recipients must all be accountable for the results. This one is difficult because it suggests that if domestic enthusiasm fades, so too should international efforts; something discussed previously that is very hard for donors to do.

This declaration was made in 2005 by the OECD, so evidently has not been effectively implemented. While coordination agencies exist, they are often hampered by a lack of enforcement mechanisms and rely too heavily on the charisma and diplomacy of the coordinating agent. The Institution OCHA is a UN agency that attempts to coordinate emergency relief (UN, 2020). It was created in 1991 and has five goals: improve coordination, humanitarian aid funding, define policy, advocation for forgotten crises, and provide rapid communication amongst aid agencies (UN, 2020). It does this through the Inter-Agency Standing Committee (IASC) whose members consist of the various UN aid programmes needed for acute emergency relief programmes. This is designed to provide a fast, comprehensive, and coordinated effort in times of crisis for humanitarian relief. Alongside these organisations is the Central Emergency Relief Fund (CERF) which is a collection of funding, set aside for emergencies so that time is not wasted when aid is needed immediately for the most vulnerable. More recently, OCHA developed the CBPF designed to pool all the funding together for one country, so that the aid effort can be as harmonised as possible. This programme is still intended for acute emergencies, but unlike CERF, it is country specific. However, between 2016 and 2018, only three countries had bought into the idea of CBPF including Belgium, Sweden, and the UK, with the UK accounting for over 63.6% of the total funding (OCHA, 2019). Nonetheless, perhaps the solution to the healthcare fragmentation of Sierra Leone is an international body, similar to OCHA.

Although OCHA exists for short term emergency intervention, the idea of pooled funds has been tried in different countries and by different agencies, in line with the OECD principles of greater coordination and harmonisation for longer term projects. In 1996, Mali was chosen as a case study for fund pooling by the OECD and pioneered by the EU who had already pooled lots of its member states' funding (Bourguignon and Platteau, 2015). The increased coordination and improved dialogues between the agencies and the government led to an increase in trust between the donors and Mali. It

was noted how the coordination worked particularly well in the subsectors of health and education but fell short on delivering its goals at the wider development level (Bourguignon and Platteau, 2015). It was especially effective at sharing information and creating common solutions to the problems found. The existence of the fund pooling was noted to reduce the transaction costs for both Mali and the various aid agencies as well as for the government of Mali who now only had to deal with one aid representative (Bourguignon and Platteau, 2015).

However, the lack of ownership and self-determination from the recipient government hampered the coordination attempt. The duplication of structures remained as the aid agencies were not fully incorporated into one body and a large body of staff and roles were maintained. Some agencies refused to join the coordination attempt as their interventions were mainly project based and ongoing, with new agencies equally unlikely to get onboard. Most of the donors were unwilling to pool their financial resources into a common initiative, especially the larger countries that had more to lose in regards to their political influence (Bourguignon and Platteau, 2015). These larger donors were unlikely to reduce the parallel structures and communication links that they had with the local government. Additionally, the long-standing autonomy on the part of the aid agencies created resistance to the EU's efforts to increase coordination with their Code of Conduct on the Complementarity and Division of Labour. Furthermore, the EU's delegation to Mali that was in control of the pooled funds was regarded as relatively strict and frequently withheld aid to the country whenever the outcomes were disappointing. Yet not all the aid agencies agreed with the EU's evaluation system and often felt that their suspension of aid was too harsh, so continued to operate despite the EU's suspension (Bourguignon and Platteau, 2015).

In October 2012, in response to the developing health crisis in the new country of South Sudan, the EU, Canada, Australia, and Sweden joined a funding pool, led by the UK (Cammack *et al.*, 2015). The five donors placed their funds in the hands of DFID who coordinated the aid response in cooperation with the governments five year health plan that had demonstrated their commitment. However, fighting erupted again in the country in December 2013 and a lot of the staffing and funding had to be pulled from

the country making it hard to evaluate the success of the programme. At any rate, perhaps the largest success of such a scheme was the surrendering of aid autonomy and sovereignty by the five donors that volunteered their funds for the greater efficacy of the aid. This suggests that there is political will power to put aside national sovereignty and aid as a tool of foreign policy in order to provide the best intervention possible. The mantle of pooled funding in South Sudan was taken up by OCHA's CBPF in 2015 due to the rising conflict in the country (Featherstone *et al.*, 2019). The overall evaluation suggests that the project was "…able to deliver 'operational impact' through timely and coordinated assistance to save lives, alleviate suffering, and make a difference to people's lives." (Featherstone *et al.*, 2019). It was described as a well-managed fund that could deliver fast and coordinated responses to rapidly changing situations and NGOs and other service providers were satisfied with the punctuality of payments. However, one of its weaknesses was its reliance on donations and the unscheduled and infrequent nature of them, inhibiting longer term planning and encouraging a reactive approach. A report mentioned how the majority of the funding for 2018 arrived in the last quarter and the volumes were unpredictable, making the regular multi-year contributions from DFID very valuable. Since 2018, the conflict has begun to stabilise, opening up the latest challenge to the CBPF as their challenges move from acute to chronic and their existence begins to be questioned. Despite this, the common fund has made multi-sectoral assistance part of its core strategy for the country so continues to offer horizontal interventions. Moreover, since the common fund was closely coordinated with the humanitarian response plan, there was increased cooperation and subscription from unaffiliated NGOs. To receive funding from the common pool, aid agencies had to be aligned with the common humanitarian response plan, thus safeguarding their autonomy but bringing them into a common strategy. However, it was commented that to keep this process collaborative rather than competitive remained an ongoing challenge (Featherstone *et al.*, 2019).

4.2 - The Application to Sierra Leone

Greater aid coordination appears to offer solutions to the healthcare fragmentation and disharmony seen in Sierra Leone in pursuit of UHC. The benefits of this strategy include cost savings and governance benefits (Bourguignon and Platteau, 2015). The

individual transaction costs of each aid organisation and the national government would be significantly reduced, and the accompanying steps of developing projects would be streamlined leading to greater efficacy, evaluation, and implementation. However, for donor countries and Sierra Leone alike, it would lead to a decrease in sovereignty and impede the ability to pursue national objectives. For the donors, they lose a valuable tool in their foreign policy negotiations and for the recipients, they are no longer able to play off the competition amongst donors (Bourguignon and Platteau, 2015). But what they lose in foreign policy, they gain in efficiency, and by pooling their financial resources, they spread the financial risk and burden across the donors (Dieleman *et al.*, 2018). Greater aid coordination in Sierra Leone has been attempted at the national level, with the creation of SLANGO which currently shows little promise. International efforts in countries such as MALI have shown some of the potential benefits of coordination but failed to get off the ground. This leaves the untried solution to Sierra Leone's coordination issues of an intergovernmental approach led by the UN. If OCHA's mandate was to be altered to include long term humanitarian aid, it would create a third party donor system that could enhance the cooperation and efficacy of their interventions. The essential mandate would be comparable to the failed SLANGO's; to coordinate all of the international actors and reduce the duplication of efforts. Beyond that, they would create a central forum for discussion and a unified voice for the aid community in Sierra Leone.

Taking inspiration from OCHA's CERF and CBPF, a pooled funding system would lead to the complete harmonisation of projects. If 100% pooling of funds could be achieved, then there would be no project outside of the common strategy set between the Ministry of Health and Sanitation in Sierra Leone and the intergovernmental body. This would mean that new projects would be instantly aligned, and harmonisation could be achieved in existing projects, removing duplicate efforts (Bourguignon and Platteau, 2015). It would make donations easier for private donors as there would be one common donation target and no longer multiple agents. This pooled fund would grant the institution a much larger voice when in discussions with the Sierra Leone government. This would be further supported as it would reduce the chances of aid agencies working independently and undermining the harmonised efforts of the

programme. This institution would be in harmony with international law and would be able to avoid the criticism that SLANGO came under (Kaye and Forst, 2018). Furthermore, it would contribute towards achieving the UN's goal for affordable UHC by 2030. This international body could respect the five principles set down in the Paris Agreement and help to protect the domestic motivation for reform demonstrated by programmes such as the FHCI (OECD, 2008). Under the principle of ownership, this institution would be able to work with the national government to agree upon a further national strategy of reform and work towards a UHC, under a domestic strategy. This one unified agency would reduce Sierra Leone's agency bureaucracy, and also wield much more weight and significance in these discussions. This weight would be transferred internationally as well, negotiating prices on drugs, orientating research efforts, and wider fair play. This would help with the NMSA project, as individual actors would no longer need their own supply chains, removing the supply chain fragmentation. The reduced government admin would free up time for both international and domestic actors allowing the government to address their problems and create their own solutions and reforms (Bourguignon and Platteau, 2015). It would be able to protect the national strategy from distracted issues and foreign targets and from disharmonised aid conditionality that would dilute the domestic enthusiasm and pull it in inconsistent directions. Furthermore, if apolitical, it would prevent the aid programme being another tool of foreign policy by some international donors and prevent the unethical use of aid as a bargaining chip. This would further increase its significance to the national government as it would reduce the chances of them using their participation as a bargaining chip too. By supporting the domestic reform, efforts made by the international community are sustainable as they can all be handed over to the national government once they are ready to do so. This is more likely than current projects due to an economic phenomenon known as crowding out. This is where spending in the public sector is cancelled out due to decreased spending in the private sector. A similar concept has been observed within the aid system, where the national government's health contributions drops proportionally to the aid they receive. A coordinated aid body would be able to refuse to raise their aid in response to falling national spending, forcing the national government to at least maintain their level of commitment (Torsvik, 2005). And with a strategy for reform, hopefully, increase their

level of commitment as time goes on. This could be implemented by encouraging Sierra Leone to adopt more thorough taxation as discussed previously (Sharples *et al.*, 2015). The increased coordination could focus on building domestic capacity and would operate amongst national institutions such as the NMSA and current infrastructure ending further supply chain fragmentation. The improved efficiency and reduced duplication would mean that this institution had the resources to tackle all the barriers to change simultaneously (Bourguignon and Platteau, 2015). These barriers cannot be addressed individually as they all contribute towards each other, which means they require vast resources and political will, all of which would be concentrated in such an organisation. Concentrating the agencies into one organisation would have the side effect of bringing together the talent as they would no longer be dispersed between agencies. In addition, the least effective would be streamlined and reduced to a potent and meritocratic team. Alongside this, an increase in motivation, energy, ideas, and a chance for real change may be invoked by pooling such talent together with such resources. Lessons learnt from these teams in Sierra Leone could be analysed, pooled, and shared amongst other similar teams per country and lead to increased efficiency spill over. These more effective and streamlined teams would be less of a drain on the domestic human capital and less expensive for the individual aid agencies working within this institution (Torsvik, 2005). Thus, there would be less brain drain from the Sierra Leone governance structures to the international organisations and, with their decreased aid admin, may also experience a subsequent increase in efficiency and efficacy. Communication between agencies and staffing costs would also be reduced. In short, this intergovernmental organisation would lead to increasing returns to scale in both finances and results (Bourguignon and Platteau, 2015). Ultimately, an organisation like this would be capable of long term, horizontal interventions that would focus on building the capacity of the national system, and have the political weight to encourage the national government to implement the appropriate reforms and slowly takeover the responsibility of its healthcare.

Since the onus for change would remain with the Sierra Leone government, any change in political will or unfair play by the government could result in reasonable and appropriate responses from such an institution. As mentioned, aid institutions want to

deliver aid giving them a weak bargaining position, but an impartial intergovernmental institution would be able to reduce aid levels to a coordinated, ethically sound, bare minimum until the strategy is renegotiated with the national government and changes made. This would be more effective than individual donors as they would be able to coordinate a minimum level of aid and nothing more giving them a stronger position to negotiate with the government whilst safeguarding lives (Bourguignon and Platteau, 2015). Typically, the most poorly governed countries receive large amounts of aid due to the larger degree of poverty and scope for improvement. This subsequently reduces the motivation to implement politically costly reform. However, a larger body, wielding all of the aid would be able to restrict these flows sufficiently and encourage reforms with incremental aid. One article suggests how a third party donor agency would be less poverty averse than donors so would be more rational and have a stronger bargaining position. This is because they can accept the long term time constraints of aid that are sometimes necessary for a country to commit to the required reforms and generate the political will to change (Svensson, 2000). Additionally, they would be able to communicate more effectively with the financial donors about why the aid has been withheld and to what end. This would also reduce the scope for foul play by the political elites who can no longer play donors off on each other. This would in turn further increase the efficiency of the individual aid agencies programmes financially and the efficacy of their goals. This is beyond the scope of current NGOs or international actors who ultimately want to give aid, but also cannot suffer the morality and negative publicity of withholding aid, even if the best interests of the country are at stake behind that decision, otherwise known as the Samaritan's dilemma.

In summary, the benefits of cooperation can be summarised into two benefits and one trade-off. Cooperation ultimately reduces transaction costs and improves the efficacy of the aid, with the consequence of lost political sovereignty for both NGOs and State aid organisations alike. Additionally, as evidenced by many of the intergovernmental organisations, they often require unanimous decision making and end up lacking tools of implementation and vital leadership. To create such an organisation would require immense and coordinated political will by the major powers and donors. Furthermore, questions remain over whether donors would surrender their sovereignty over where

their money goes and how it is spent. This is further questioned by organisations such as the Bill and Melinda Gates Foundation, who would see their names ceased to carry such importance as they were enveloped by the larger coordinating body. Likewise, large, and well known NGOs would see their independent financial revenue streams threatened by such coordination and would see an equivalent loss of independence and sovereignty. If private donors care about a particular cause, it remains to be seen if they would still donate if their funds cannot be earmarked to what they care passionately about. Other large international organisations with great presence and grand goals would also have to be incorporated, perhaps at the detriment to their programmes as they see their resources directed elsewhere including, GFATM, GAVI and PEPFAR. These organisations already prevented their own supply chains being integrated into a national system under a reform package that they sponsored, suggesting there would be resistance to such an intergovernmental approach. This reduced sovereignty would also affect the state donors such as DFID and USAID which may also have their own targets and goals that they wish to push but would have to surrender this guaranteed autonomy for whatever form of common decision making is decided upon. For effective and rapid decisions, this would likely require qualified majority voting, however, this would not be following a known successful formula for development and, as always with majority voting, will leave some if not all the donors discontent in one way or another. The larger organisations, such as DFID, that already enjoy a large amount of autonomy and political power would be much less likely to support coordination at the loss of their sovereignty. Though a coordination body would reduce their influence and the foreign policy tools of the UK over the country, they have shown enthusiasm for greater coordination in the past. Furthermore, one paper argues that once a critical mass of agencies is reached, the benefits of joining such an association begin to outweigh the disadvantages leading to increased cooperation (Bourguignon and Platteau, 2015). This is because increasing returns to scale are seen by pooling the resources and the benefits of joining begin to outweigh the downsides of cooperation. Although, the larger aid agencies are more capable of resisting this gravity and may choose to “freeride” on the benefits of cooperation whilst safeguarding their sovereignty over the efficacy of their aid (Bourguignon and Platteau, 2015).

These sentiments of lost sovereignty would be felt similarly by Sierra Leone who would see their domestic strategy implemented, but may bristle under the added weight and restriction that comes with such an institution (Bourguignon and Platteau, 2015). More effective aid conditionality and coordination would restrict the ability of the elites to play actors off each other and pursue their own personal political machinations (Bourguignon and Platteau, 2015). This would also result in reduced NGO independence and the common funding would make it harder to criticise the programme and the domestic government, as funding could be at risk if that organisation becomes unfavourable (Kaye and Forst, 2018). This was a criticism laid on SLANGO but would hopefully be reduced by the political responsiveness of this intergovernmental organisation. Such an institution will naturally disappoint some donors if it operates a form of majority voting so is not likely to be short of criticism on the international scene. This lack of independence could also make it harder for bottom-up, grass root ideas to take form, an aspect of development that is key to actors such as the WHO and the EU. This could be further compounded by neglected areas, as fewer actors could mean areas go unnoticed or under prioritised (Kaye and Forst, 2018). These areas of contention and debate would help to keep the institution ethically sound and apolitical. Ultimately, such an institution would only work if it had the full support of the actors at its creation, implementation tools to be able to maintain cooperation, and overriding support from the major players. Because of these commitments, it seems unlikely that such an organisation would be able to remain apolitical in order to guarantee its funding and fulfil its mandate, presenting an inherent flaw in such an idea. If such an institution fails to remain apolitical, it would also be harder for it to stand as an impartial donor, resistant to the Samaritan's Dilemma in pursuit of long term improvement. Whether this is a correct evaluation remains to be seen, but the development of OCHA's mandate to include long term humanitarian aid offers a novel solution to the issues seen in Sierra Leone's healthcare system and could potentially carry the resources to help Sierra Leone surmount its barriers to change in pursuit of a UHC in line with the SDG plan for 2030.

Conclusion

Sierra Leone's colonial history and the difficult path towards independence have left it with many institutional deficiencies that the country faces today. Coupled with this, the multitude of crises over the past eighteen years since the civil war ended, have systematically undermined attempts to correct these institutional insufficiencies. As this thesis has shown, efforts by the international community to deal with the crises has helped save lives but left its scars on the national system that it leaves behind. These have manifested in a fragmented healthcare system demonstrated by the supply chain, the CHW programme, and the SLAs. Additionally, multiple other foreign programmes are operating in the country in pursuit of the SDGs such as GAVI, GAFTM and PEPFAR. These organisations often work independently and pursue narrow vertical interventions, further undermining the national system's ability to tackle these problems on their own. This was seen in the most recent reforms of the supply chain where these organisations sponsored the restructuring but left their own supply chains out of the process. Furthermore, their operations and the actions of expanding NGOs also remove the political pressure to address these issues from the central government. All of these contribute towards the barriers to UHC. These include the internal barriers of institutional efficiency, economic limitations, and social hurdles, including trust, motivation, and coordination. Alongside these are the external barriers to UHC, identified as a lack of coordination between the Sierra Leone government, NGOs and state actors, including inconsistent aid conditionality. The Samaritan's Dilemma explains how aid providers find themselves in a conundrum, as they want to supply aid yet risk punishing recipient governments at the expense of the poor. Additionally, the lack of coordination removes any potential benefits from aid conditionality as the actions can always be undermined by one of the multifarious actors. Key efforts have been made to address these barriers to change such as SLANGO and the FHCI. SLANGO attempted to bring all the NGOs under one coordinating banner, to harness their financial and technical capacity, bringing their strategies in line with a common domestic direction. This ultimately failed due to institutional deficiencies and backlash from the proudly independent NGOs and smaller aid operators. The FHCI attempted to overcome the internal barriers to UHC and was relatively successful but failed to remove hidden charges. This is likely due to the institutional insufficiencies, but it is

challenging to provide a complete analysis since the programme was catastrophically undermined by the ebola crisis and the subsequent international response. Following these failed attempts to overcome the barriers to UHC, this thesis considered the history, attitude, and declarations made by the international community to address the aforementioned issues. More recently, calls for greater coordination have been taken up by the WHO, the UN, and the OECD. The Paris Declaration in 2005 declared an agreement to foster five principles: ownership, alignment, harmonisation, results, and mutual accountability. This thesis argues that an international organisation resembling the UN's OCHA would be able to adopt the mandate of SLANGO to support domestic initiatives such as the FHCI. The benefits of such an organisation result from increasing returns to scale and the foresight of an institution prepared for a long term investment. There would be cost savings from reduced administration, duplication of projects, and more effective utilisation of domestic resources. The pooled funds in a manner similar to CBPF would create an instant harmonisation of projects and help to spread the financial risk and burden across all of the international actors. This would be coupled with an easier donation system and streamlined evaluation for greater coordination. This large institution would carry greater weight on the international stage, granting it a louder, unified voice when dealing with both the government of Sierra Leone and negotiating prices for projects such as the FHCI and the NMSA. This would allow for more effective aid conditionality to encourage reform and the ultimate goal of complete ownership of the programme by Sierra Leone, making the intervention sustainable. The organisation would be in line with international law and avoid the criticism that SLANGO fell under while remaining apolitical and preventing aid from being a tool of foreign policy. However, with the loss of aid as a foreign policy tool, states would be surrendering their influence in this domain of the international stage. Equally, NGOs and state agencies alike would experience a loss of sovereignty by a shared decision making system implicit in an international organisation. Majority voting is certain to leave some actors discontent as they are forced to compromise and form package deals. This would be felt the most by the largest aid contributors who would experience the largest loss in political gravitas. Equally, the government of Sierra Leone would experience a loss of political freedom as they find themselves no longer capable of playing off the individual actors. Additionally, previously mentioned positives such as

more effective aid conditionality have yet to be proven. It has been hypothesised that an international body would be less susceptible to the Samaritan's Dilemma, yet this remains relatively untested. Furthermore, whether the larger aid agencies would be willing to make these sacrifices remains to be seen, making this proposal an interesting yet hypothetical solution to the healthcare fragmentation seen in Sierra Leone today, in pursuit of UHC.

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Appendix A

Table I – Showing the local salary discrepancies, including benefits, between the local government and the various aid agencies in the Democratic Republic of Congo.

Local Gross Salaries (including benefits) in the DRC – Monthly earnings							
Category	Example	Local government*	Local NGO	American NGO	European NGO	European Embassy	UN***
Year		2014	2015	2014	2016	2016	2014
Low-Skilled Worker	Guard, Cleaning staff	$78	$80	$191	$299	$787	$1164
Semi-Skilled Worker	Driver, Receptionist	$84	$117	$317	$398	$1057	$1339
Skilled Workers	Finance Assistant	$87	$141	$593	$709	$1534	$2570
High-Skilled Workers	Technician	$92	$232	$732	$948	$2245	$3614
Management Staff	Team Leader	$101	$471	$1083	$1947	$2724	$7524
Director Level	Organisation head	$107	$592	$1240	$3010	$4025	$10,775
Other	High Ranking Soldier	$102					
	Experienced Teacher	$120					
	Doctor	$1108					
	Judge	$1181					

*Source: Ministère du Budget (2014) Tableau Synoptique De L'Evolution Barémique Par Secteur De 2007 A Ce Jour (including benefits).
**Exchange rate used: average exchange rate for 2014 = 1260 Congolese Franc for USD.
***Source: United Nations (n.d.) Salaries scales for staff in the general service and related categories. (Koch and Schulpen, 2018)