Guaranteeing Democratic Accountability in the Context of a Humanitarian Crisis:

A Case Study From the Recent Ebola Crisis in the Mano River

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Note on the paper

This paper was written for and presented at EISA's 20th Anniversary symposium which took place on 20 and 21 October 2016. The theme of the symposium was: ***Current Democratic Realities in Africa: Where Are We Headed beyond the Vote?*** The symposium focused on the continent's democratic triumphs - those elements pulling States closer to democratic consolidation - while also acknowledging the democratic shortfalls - pushing African States backwards. In reviewing progress and challenges confronting the continent, the symposium provided a platform for democracy promotion stakeholders to examine current democratic realities in Africa and where the continent is headed on the current wave of democracy. The symposium covered a range of topics and provided a platform for democracy-promotion stakeholders to review the progress and challenges recorded at national and regional levels. The annual event also served as a lesson sharing and learning opportunity for democracy-promotion stakeholders as they deliberated on the development of shared culture of best democratic practices. The symposium proceedings are available at http://eisa.org.za/pdf/symp2016cp.pdf

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Introduction

The first case of the Ebola Virus Disease (EVD) in the Mano River Union (MRU) region was reported in the forest region[1] of Guinea in March 2014[2]. The initial response of communities in the entire MRU was total denial. The indifference of local communities was fueled by their doubt about the imminent danger the EVD posed due to the lack of medication to heal infected persons, which also affected the initial response to the pandemic. The virus spread rapidly across three MRU countries, Sierra Leone, Guinea and Liberia, and quickly took on a global dimension. The exponential manner in which the disease spread captured the attention of the world and the magnitude of the epidemic prompted a massive humanitarian response led, belatedly, by the World Health Organization (WHO). At the onset, the epidemic was treated with disturbing levity. This was probably due to the level of ignorance on the part of the citizens, and most especially the governments, about the far-reaching implications it could have on the very existence of their states. There was very little knowledge in all facets of society about infection, prevention and control (IPC) measures, further compounding misperceptions about the disease. The pace at which it spread clearly exposed the lack of accountable, effective and efficient governance structures in the region. This in turn affected the response of central government and relevant ministries, departments and agencies (MDAs), including local governance systems – where they functioned. Medicins sans Frontiers (2014) commented that 'the governments of Guinea and Sierra Leone were initially very reluctant to recognise the severity of the outbreak, resulting in a lethargic early response. This is far from unusual in outbreaks of Ebola – or indeed other dangerous infectious diseases; there is often little appetite to immediately sound the alarm bell for fear of causing public panic, disrupting the functioning of the state and driving away visitors and investors'.

Consequently, citizens became victims of their governments' inept structures and systems. There was a degree of dishonesty on the part of governments as they delayed the pronouncement of Ebola as a health emergency[3] and played catch-up on all fronts.

The lack of experience in dealing with such a disease, and political manoeuvering at national levels especially in the three most affected countries, was a compelling justification for the international

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1 The MRU is a sub-regional political and customs union comprising Guinea, Cote d'Ivoire, Liberia and Sierra Leone.

2 http://who.int/csr/disease/ebola/one-year-report/virus-origin/en/ Despite the Guinea Ministry of Health's first alert to the unidentified disease on 13 March 2014, several lives had been lost since December 2013. On the same day WHO's Regional Office for Africa (AFRO) formally opened an Emergency Management System for a disease suspected to be Lassa fever. A major investigation with staff from the Ministry of Health, WHO AFRO, and MSF, took place from 14 to 25 March, involving site visits to Kissidougou, Macenta, Gueckedou City and Nzerekore.

3 http://www.statehouse.gov.sl/index.php/useful-links/925-address-to-the-nation-on-the-ebola-outbreak-by-his-excellency-the-president-dr-ernest-bai-koroma-july-30-2014. President Ernest Koroma finally declared a State of Public Emergency over two months after the EVD's index case was announced in Sierra Leone when he announced that 'The disease is beyond the scope of any one country, or community to defeat'.

community to launch a robust humanitarian intervention. The nature of the intervention had to transcend the immediate emergency nations were faced with in a more robust and holistic fashion. This paper will interrogate the definition of accountable governance and its nexus in humanitarian response, and use the social and political accountability approaches examined by Andrés Mejía Acosta (2010) as core principles for democratic accountability. Acosta outlines four ideal criteria to evaluate the effectiveness of accountability: standards, answerability, responsiveness, and enforceability. He further asserts that a key premise and promise of the democratic wager is that citizens can hold government officials accountable for the provision of public goods and services. Democratic governance in humanitarian situations still requires respect for prescribed standards to be accompanied by sanctions for actions. This obviously requires the effective operation of institutions and processes in a democratic environment. Anders Hanberger (2006) suggests that one analytical distinction to consider is the difference between vertical and horizontal accountability, and that 'the traditional notion of democratic accountability refers to ways that citizens can control their government and the mechanisms for doing this'. According to Edward Weber, the meaning of the term has shifted over time and 'Each conceptualization emphasizes different institutions and locates the ultimate authority for accountability in differing combinations and types of sectors (public, private, intermediary), processes, decision rules, knowledge, and values' (Weber 1999, cited by Hanberger 2006, p. 453).

With diverse perspectives on humanitarianism gaining traction, it is clear that the trajectory is shifting to the notion that actors are 'no longer satisfied with saving individuals today only to have them be in jeopardy tomorrow – the infamous "well-fed dead" – many organisations now aspire to transform the structural conditions that endanger populations' (Barnett 2008, p. 3). It is these structures that all MRU countries must try to build in order to ensure institutional resilience and to prevent a similar or even more devastating eruption the EVD in the sub-region.

The EVD's impact permeated all facets of society, and the economies of all three most-affected MRU countries suffered hugely. Mining companies were forced into administration leading to massive unemployment in Sierra Leone when companies like London Mining and Africa Mineral closed down, while Addax Bioenergy Company was forced to evacuate several international and national personnel. In Liberia, the story was the same, as Arcelor Mittal pulled staff out of the country for health and safety reasons (NewDawn, 2014). As the EVD took its toll on the economies of these countries, even international travel options became limited and British Airways, one of three main carriers that plied the Sierra Leone EU countries, led the way for a fleet of airlines to suspend operations to Sierra Leone.

Several questions remain unanswered as the region progressed with post-EVD recovery initiatives:

- What is the level of involvement of communities in the implementation of plans that seek to improve their situation;
- Did the governments learn any lessons from the (lack) coordination of international partners;
- In what way did humanitarian response undermine the authority of individual states;
- What would the countries do differently to ensure sustainability of investments in their countries, particularly in the health sector;
- Are citizens part of the decision-making processes in these countries;

- What possibilities/signs exist for a paradigm shift in the efforts on the part of government and citizens towards strengthening the social contract between both parties; and
- Could the EVD serve as a wake-up call for societies to demand more accountability from office bearers.

This paper will attempt to answer these questions through an assessment of the overall humanitarian and governance responses by the respective MRU countries and partners to manage the situation. It will also attempt to assess the role of institutions, governments, international partners and citizens in eradicating the virus in the sub-region. This will also be an opportunity for a critical interrogation of the structures implemented by the four MRU countries to manage the situation; Sierra Leone, Guinea and Liberia that were hardest hit; and Cote d'Ivoire that quickly put preventive measures in place to stop the spread of the scourge into the country.

The EVD Outbreak

The Government of the Republic of Guinea announced the index case of EVD in the MRU basin on 23 March 2014 after a case of Ebola virus was reported in a small village in Guinea (WHO 2014). The victim was a toddler who later became known to the world as Patient Zero. He died on 6 December 2013 at the age of two, and the domino effect of his illness has spiraled, ravaging three nations in West Africa (Gholipour 2014). Sierra Leone later reported its index case on 29 May of the same year. Although researchers believe the EVD virus had been present in the West Africa sub-region long before the 2014 outbreak , the magnitude of the 2014 outbreak[4] was incomprehensible. The disease quickly spread across the borders of the MRU, leaving in its wake over 11 310 deaths and 15 227 infected persons.

The healthcare services of the three worst affected countries were in dire straits. Maternal mortality levels were very high: about 6 000 maternal deaths were reported in 2013 in the three countries combined; and malaria, associated with over 20 000 deaths each year, was the major cause of morbidity in health facilities (30-40% of diagnoses). There was only one doctor for 30 000 people in Sierra Leone and Liberia, and most of the health workers were based in the capital cities. The capitals of Sierra Leone and Guinea both have about 16% of their country's population but half of all health professionals (Guardian 2016; WHO 2014). The epidemic was bound to thrive in such an environment. Unlike the three most-affected countries that will be the focus of this paper, Cote d'Ivoire's situation was slightly different because their focus was on preventing transmission. This they did fairly well considering the porous borders that facilitate travel through unofficial routes.

Entrenched socio-cultural beliefs and practices in closely-knit communities made it more onerous to prevent the spread of the EVD. Adherence to traditional practices was cemented by the secret societies that are the fulcrum around which the communities revolve and are governed. Key traditional practices include shaking hands as a show of respect and courtesy, and washing corpses by family and members of male and female secret societies. This was prohibited during the outbreak as the

[4] http://www.eurekalert.org/pub_releases/2014-07/uamr-sls071414.php. Analysis of clinical samples from suspected Lassa fever cases in Sierra Leone showed that about two-thirds of the patients had been exposed to other emerging diseases, and nearly 9% tested positive for Ebola virus.

EVD thrives in dead bodies. It therefore became apparent that the social mobilisation messages had to be contextualised and disseminated through appropriate persons, and not by anyone who lacked the trust and confidence of the citizens.

National and International Response

Traditional rulers and structures played a significant role in curbing the transmission of the EVD across the MRU. In Liberia, WHO worked with local leaders to conduct social mobilisation activities through the National Traditional Council in all 15 counties. In Sierra Leone paramount chiefs in the Kailahun and Kenema districts crafted local bye-laws which were effectively implemented and replicated across their chiefdoms; the same was eventually done in other districts across the country. This was a clear indication and reminder that the governance paradigm must shift from an over-centralised approach to a community and people-driven system. In Liberia, this community-driven social mobilisation and disciplinary measure was escalated to the higher level of local district councils. Liberia's Lofa County has been cited as a model of local and international collaboration, including lengthy consultations with humanitarian aid workers who had long been in the area. The population changed its norms and cultural practices during the spike in infections in June 2014, as treatment centres became viewed as 'not only a place to die' (International Crisis Group Africa 2015). Eventually, the investment in community initiatives further cemented the crucial role that local authorities could play in promoting the effective delivery of services, peace and prosperity as paramount chiefs in eastern Sierra Leone established bye-laws that governed their communities during the EVD outbreak.

Politicising the EVD response and its impact

The initial announcement of the EVD outbreak in Sierra Leone was greeted with misgivings and accusations by the main opposition Sierra Leone People's Party (SLPP). The belief was that the ruling All Peoples' Congress (APC) wanted to depopulate the SLPP's strongholds ahead of the National Housing and Population Census, hence the tepid reaction of the government to the outbreak. The opposition SLPP accused the ruling APC government of indifference to the EVD crisis because Kailahun District, which was first hit by EVD as it was in the civil war, is an opposition stronghold. Government was expected to have taken a much more proactive and robust response in order to restrict the EVD to the eastern region. Instead, the response by all concerned to what was a devastating epidemic again reflected the lack of political maturity needed to include all stakeholders in an inclusive response.

The EVD also impacted on activities targeting elections as a key governance accountability tool. Liberia and Guinea conducted mid-term senatorial and presidential elections respectively, amidst concerns about the spread of the EVD. While their respective constitutions demanded that those elections be held, it was clear that the citizens also demanded elections because they were unsure about postponement intentions by their government – another pointer to the lack of trust and confidence in the political elites. Consequently, voter turnout in Guinea was low but it was still a close race. Unlike Liberia and Guinea, Sierra Leone postponed the National Housing and Population Census scheduled for December 2014. Sierra Leone's constitutional review process was also delayed

as a result of the EVD outbreak. This could also impact on the timeline for the presidential and parliamentary elections scheduled to take place in early 2018 should the government decide to proceed with a referendum.

In Sierra Leone, the president's declaration of a state of emergency due to the EVD epidemic was characterised by restricted movement in areas affected by the disease; restrictions of public meetings and gatherings; surveillance; house-to-house searches for Ebola victims and people who had had contacts with victims; and screening at the country's main ports. In essence, the epicenters of the disease were subject to a cordon sanitaire.

Government

Similarly, the EVD highlighted the rift in the social contract between citizens and states, and elected and/or appointed officials at both national and sub-national levels. This was glaringly obvious when some local authorities, including paramount chiefs and members of parliament (MPs), were provided with funds to embark on EVD prevention and management campaigns using diverse information, education and communication (IEC) tools (Cham 2014; Senessie 2014). Citizens were clearly outraged when they learned that their constituency development funds[5] had been allocated to MPs to embark on public awareness campaigns to help eradicate the EVD in their localities.

Government has released seven point eight billion Leones as constituency Development Fund for the fiscal Year 2014 as part of efforts to combat the Ebola outbreak at constituency level. A release issued by the Ministry of Finance and economic Development states that the fund is to enable members of Parliament provide oversight, leadership and contribute to the fight against Ebola in their respective communities[6].

Public outcry was a clear manifestation of civic misgivings about the alleged conduct and the effectiveness of MPs in promoting oversight and accountability for national resources. One school of thought believes that MPs 'know their localities and their people well' and should be leading the EVD battle; accountability activists believe that MPs should be held accountable for funds that they have received. The call of the accountability activists has been met by fierce criticism and the scrutiny of parliamentarians. It is also allegedly the reason for the all too sudden scrutiny of NGOs calling for parliamentary accountability. To date, we are not aware of any audit of the constituency development funds by Audit Service Sierra Leone. This mistrust of citizens permeates all facets of engagement between the two stakeholders, government and citizens, and is a true reflection of the mistrust that has grown over the years across all three MRU countries. In the eyes of the ordinary citizen, MPs or their local authorities are complicit in the alleged misappropriation of resources intended for the effective delivery of social services. This lack of trust and confidence in the elite permeates the entire MRU region. It even became an impediment to the social mobilisation efforts in Guinea, where eight health workers, journalists and politicians were murdered in the forest region when they tried to sensitise local communities about Ebola (BBC 2016).

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[5] Constituency Development Funds are provided by government to aid community development initiatives by MPs. There are suggestions that such a move to provide members of the legislature with resources for community development undermines the spirit of the Sierra Leone Local Government Act of 2004 which puts local development within the remit of the local councils.

[6] http://www.slbc.sl/govt-releases-7-8-billion-leones-as-constituency-dev-fund/

Suspension of Citizens' Constitutional Rights

Like most natural, man-made and health disasters, the control of EVD demanded compelling changes to the daily operations of society. National health emergency powers restricted the movements of people by declaring a State of Emergency (Mark 2014) which was tantamount to a suspension of the constitutional rights enshrined in the bill of rights. In most cases, the police and armed forces of the most-affected countries were deployed to enforce quarantines and lock-downs.[7] They also disallowed public gatherings as spelt out in the bye-laws and legal instruments of the localities and countries in question. Security personnel were deployed to search for high-risk and exposed people and a breach of normal search and entry and detention protocols, such as holding centres, was allowed by law. Under certain circumstances, it might be necessary to restrict movements by quarantining homes and villages (Spencer 2016). Nonetheless, in Sierra Leone civil society activists and the opposition SLPP continued to register their dissatisfaction at the apparently permanent state of emergency because of the selected use of the legislation. In their view, the state of emergency applied to only a select few, depending on which side of the political divide they belonged (Sierra Leone Telegraph 2015).

Judicial Response

The Sierra Leone judiciary enforced the emergency regulations announced by President Koroma. The judiciary is expected to be independent but the public perceived it as corrupt and under the influence of the executive, and people were unjustifiably detained without trial. The apparent inaction or unwillingness of the judiciary to try persons alleged to have committed crimes seemed like acquiescence to government's efforts to detain citizens unlawfully. This added to a lack of trust and confidence in the judiciary.

Security Sector Involvement

Following the emergency pronouncements in Liberia (Paye-Layle 2014) and Sierra Leone, security personnel became an integral part of the EVD response. This securitisation seemed to have been inspired by the international response championed primarily by British, American, French and Chinese military personnel. It proved to be extremely helpful as they complemented national and international health experts.[8] However, the pivotal role of the security sector, especially police and military, raised questions about the role of and respect for these forces even though they seemed to be under civilian authority. There were anecdotal instances of an informal 'Ebola economy' promoted by the establishment of security checkpoints and passes issued for quarantined areas. These were coupled with demands from security personnel to pay for access to certain parts of the country, or to break curfews imposed by government. There were also rampant reports of human rights abuses by the same security forces expected to promote the wellbeing of their compatriots. 'These abuses raised tensions within communities and added to mistrust of government.'(Kabia 2014)

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[7] Lockdowns were movement restrictions instituted by Governments to curtail the spread of EVD

[8] Interview, OB Sesay, Head of Sierra Leone Ebola Situation Room of the National Emergency Response Center (NERC). He asserts that the wealth of experience by the British in coordinating logistical support for a nationwide emergency mission of that magnitude was invaluable because hitherto NERC could not effectively track assets and project the needs of various treatment facilities, burial and social mobilisation teams.

Another measure introduced to curb the transmission of the EVD was that of limiting trading to specific days and hours. The rationale given by government was to minimise human contact and overcrowding, and in many ways, emergency legislation provided some kind of spurious legitimacy for violating civil rights as persons remained in detention, and other rights, including that of assembly, were curtailed.

There were violent protests in all three countries: Koidu in eastern Sierra Leone experienced riots and deaths; in Nzerekore and several other locations in Guinea; (Telegraph 2014) and riots at West Point section in Monrovia, Liberia (Gayle 2014). Thus, a lack of trust between communities, the government and health care workers further prolonged the spread of EVD and it was only when it became a matter of life or death that the people began to trust the educational campaigns.

Fiscal Accountability in Emergencies

Ensuring donor coordination and accountable governance in an emergency like the EVD outbreak was an onerous and critical task for the most-affected MRU countries that are constantly embroiled in allegations of corrupt practices that continue to undermine their development. The possibility of effectively promoting accountability and transparency during emergencies continues to fuel debates across all sectors, because a strong correlation exists between corruption and the lack of basic social services. Huguette Labelle, Chair of Transparency International described it thus:

Corruption and poverty unfortunately go hand-in-hand, threatening the lives of too many people. In countries where people are forced to bribe to get essential services like health and water the toll can be horrifying. Eight times more women die having children in places where more than 60 per cent of people report paying bribes, compared to countries where bribery rates are less than 30 per cent. (Labelle 2014)

The EVD response was no exception to this argument. By the time WHO had declared Public Health Emergency of International Concern (PHEIC) on 8 August 2014, in response to the outbreak of Ebola in western Africa, the situation had become perilous for inhabitants of the sub-region. The nexus between accountability and effective service delivery by institutions and individuals charged with the responsibility of leading the EVD management response was of major interest to all parties. However, there is still no verdict on how effective they were. Civil society led the demand by citizens of all three countries for accountability. This should not have come as a surprise to governments which remained adamant about the prudence of their fiscal systems. In Sierra Leone, the accounting firm KPMG offered their technical expertise as part of their EVD response to the Emergency Operations Center. This was the first attempt at institutionalising the EVD response, even though KPMG later pulled out of the partnership (Sama 2015). KPMG's decision, coupled with Report on the Audit of the Management of the Ebola Funds by the Audit Service Sierra Leone, indicated that there were 'lapses in the financial management system in Sierra Leone and these have ultimately resulted in the loss of funds and a reduction in the quality of service delivery in the health sector'(Sierra Leone 2014). Allegations of the mismanagement of Ebola resources in Sierra Leone in February 2015 further deepened the mistrust between citizens and the government. In Liberia and Guinea, the situation was not very different. A worrying fact is that 'donor funds

channeled through implementing agencies such as the UN and INGOs…and information on the quantum of monies received and how they have been expended for the purpose of supporting the response to eradicate the EVD have not been fully audited' (ibid.). This puts the international community under the microscope for the opaque manner in which their funds were managed. Again, questions continue to be raised about the accountability of international partners like the UN, the UK's DfID, and USA, regarding the way funds were managed for and on behalf of the people of Sierra Leone. Mostly, they engaged service providers directly through their local, on-the-ground representatives, though some used off-shore technical experts. What remains unbelievable is that the United Nations charged an infamous 5% administrative fee for funds channelled through them for the EVD response.

International Response

The initial international response to the EVD pandemic was neither effective nor adequate. There were unconscionable delays on the part of WHO to declare the Ebola virus disease outbreak in West Africa a Public Health Emergency of International Concern (PHEIC) under the International Health Regulations (IHR 2005; WHO 2014b). It took five months after the announcement of the first positive EVD case in Guinea in March 2014; and almost three months after the first case, and the deaths of 99 confirmed cases, in Sierra Leone by end of July (Gibandia 2014) for WHO to take action. The WHO needed the governments of the MRU countries to take leadership in declaring a national health crisis, which didn't happen early enough.[9] Although it has become the norm for members of the international community to help populations in distress, there was an initially dismal response by the international community, especially WHO, to the EVD as a humanitarian crisis. This claim was further confirmed by an assessment of the response to the epidemic by WHO as an institution (Boseley 2014), which further indicted the world health governing organisation. The assertion by Klingebiel and Sehovic (2014) is that 'to a large extent, the situation was caused by chronic underfunding of the core functions of leading international institutions'.

The World Health Organization only declared a global health emergency on 8 August 8 2014. While the body was expected to respond much earlier in a coordinated and purposeful manner, 'the WHO's two-year budget fell by more than 20 percent, from nearly $5 billion in 2009–2010 to $3.98 billion in 2014–2015'[10], and their response was decidedly lacklustre in the initial phase of the outbreak. Together with the apparent prioritising and shared interventions by former colonial powers in all three of the most-affected countries in the region the United Kingdom in Sierra Leone, the French in the Republic of Guinea and the United States of America (USA) in Liberia this was another reminder of the post-colonial influence that former colonial powers continue to wield. While it is often stated that 'humanitarian action is couched in the very strong language of moral duties, obligations, and responsibilities' (Barnett & Stanyder 2008), there is a duty to offer aid. Why it took the world health governing body so long to intervene proactively, and whether the national

[9] President Koroma declared a State of Public Emergency only on July 30, 2014. Within this framework, the police and the military would support health officers and NGOs to do their work unhindered and would restrict movements to and from epicenters. Localities and homes where the disease was identified would be quarantined until cleared by medical teams. Paramount chiefs were required to establish bye-laws that would complement other efforts to deal with the Ebola outbreak.

[10] http://www.cfr.org/public-health-threats-and-pandemics/world-health-organization-/p20003. WHO's slow response to Ebola has been attributed to budget cuts, and in 2014 WHO leaders petitioned governments around the world to increase funding to fight Ebola. A New York Times analysis found that the WHO's outbreak and emergency response team was hit particularly hard by cuts; officials in that department estimated their staff had been reduced by 35% since 2009. The WHO department charged with emergency response was reduced from 94 to 34.

institutions abdicated their duties to international bodies, was queried by many during and even after the EVD. There were also questions asked about how effective coordination efforts were in responding to the humanitarian emergency.

The Ebola outbreak spread as a result of weak health care systems in the three most affected MRU countries (Murphy & Ricks 2014), as the governments of these three countries lacked the ability to guarantee health care for its citizens. Senegal, Mali and Nigeria responded quickly and ended the outbreak before it could spread further. However, none of the other three countries could cope with the rapid spread and devastation of the EVD as it devoured nations that lacked basic health governance infrastructure. The situation was further compounded by the fact that:

The international reaction was ... problematic and rightly criticised as dysfunctional and inadequate by many observers. Early warnings were largely ignored until cases began cropping up in the U.S. The World Health Organization (WHO), which had stalled for far too long on declaring an international health emergency, then proved incapable of mounting an effective response. The Security Council was forced to create a new body to scale up and coordinate operations – with variable results – the UN Mission for Ebola Emergency Response (UNMEER).

(International Crisis Group 2015)

The Report of the Ebola Interim Assessment Panel, selected to assess the response by WHO to the Ebola outbreak, blamed the agency's politics and rigid culture for the poor response to the epidemic. As an inter-governmental organisation WHO may not have been able to announce the magnitude of the crisis on its own. This report further states that 'the Ebola crisis not only exposed organizational failings in the functioning of WHO, but it also demonstrated shortcomings in the International Health Regulations (2005)'. The UN's face-saving efforts to have a coordinated response through UNMEER became the lifeline for the UN system's embarrassing response to the EVD epidemic. A member of the WHO Ebola Emergency Committee, Oyewale Tomori, heavily criticised the response by saying 'It was an escalation of incompetence all the way to the top' (Fox 2015). Tomori, a member of the separate WHO Ebola Emergency Committee, told the Associated Press that he thought the report should have named names.

The EVD epidemic was another opportunity for Britain, France and the United States to reaffirm their support for the affected MRU countries. While these former colonial masters of the three most affected countries paid more attention to their respective countries of primary interest, they also provided bilateral support to other countries (WHO 2016). By 22 April 2016, WHO had received over US$459 million in direct and in-kind donations from over 60 donors. Most of this funding for Ebola-related activities came from governments and multilateral organisations. The largest donors were the United States of America, the World Bank, the African Development Bank, the Ebola Multi Partner Trust Fund, and Japan.

As of February 2015, the UK government was reported to have committed up to £230 million in direct support to help contain, control and treat the Ebola outbreak in West Africa, with the total funding believed to rise to £330 million.

The United States led efforts to and seemed to commit more resources to Liberia, the French focused primarily on Guinea (ambafrance 2014),[11] while the UK directed most of its support to Sierra Leone. It is worth noting that while these western countries provided invaluable technical support, funds and diverse forms of humanitarian support for the EVD response in Sierra Leone, their funds did not go through the Ebola national funds management and monitoring systems.

Regional Co-ordination

The initial response of most African countries was to close their borders to Sierra Leoneans and stop flights to Sierra Leone. This was understandable; in the midst of panic, governments could be seen taking concrete actions to protect their citizens from a disease that even health experts said had no cure. The African Union (AU) was criticised because it took them ten months before holding an emergency summit on the outbreak, after which they eventually responded. The AU, through its African Union Support to the Ebola Outbreak in West Africa (ASEOWA), deployed a team of 885 military and civilian medical doctors, nurses and other medical personnel, as well as military personnel, on a special humanitarian mission. The AU released $1, 000 000 from their Special Emergency Assistance Fund for Drought and Famine in Africa in August 2014 (Musabayana 2016). The Economic Community of West African States (ECOWAS) also designed a multipronged approach to the EVD response as they convened meetings of security and health experts at different times to discuss the implications and response to the epidemic (Harmon 2014).

In the small MRU region with about 23 million citizens moving across very porous borders, the call for closures and restrictions of movement by citizens, and the subsequent decision of the governments to heed this call, was one of the easiest steps taken to curb the cross-border transmission of the EVDs. The closure of those official borders was, at best, a populist and kneejerk response to a bigger problem that required community-driven and people-centered engagements with the support of national infrastructure. This assertion is made on the grounds that the three most affected countries have even more unofficial and unmanned entry points which are maintained to sustain family and ethnic ties across the borders, and also subsistence economic activities such as farming and petty trading.

Lessons

The EVD response harnessed local community resources geared towards social mobilisation in an effort to reduce the transmission of the virus within and beyond the shores of the affected countries. The involvement of traditional authorities who have always been powerful in Sierra Leone and Liberia, was invaluable for the IPC of the EVD. The pandemic brought back a homegrown approach to governance - a lesson that decentralisation works because local government officials know their issues better than central government officials.

[11] France agreed to contribute € 110 million to the fight against Ebola through its bilateral action in 2014 and 2015. 80% of the French contribution goes in direct financial assistance, 12% on logistics (transport, cargo, etc.) and 8% to providing French workers.

Similarly, the involvement of community-based and civil society organisations helped to bridge the gap between citizens and local authorities. In the midst of the mistrust of government institutions and local authorities, mainstreaming the voices of local leaders was critical for the fight against the virus. This partnership also contributed to building trust between the government and its citizens, especially at grassroots level. This involved a reduction of corruption, better management of public funds, transparent access to and sharing of information. As David Cameron said while referring to the merits of local governance accountability 'when you shift power to the bottom, you reduce the bills at the top'(Cameron 2009). This is because they are trusted, credible and influential in changing the behaviour of community members. For instance, in Cote d'Ivoire, interventions by non-profit organizations like Agence d'Aide a la Cooperation Technique et au Developpement (ACTED) who were actively involved in prevention efforts, deployed information hotspots and mobile teams that targeted popular points of citizens' convergence and helped prevent EVD (ACTED).

Learning from the experience of next-door neighbor Liberia and the other two MRU countries, the government of Cote d'Ivoire took precautionary measures to halt the spread of EVD into their territory. Their government took charge of the entire EVD prevention structure through its Ministry of Health to ensure that partners' support was centralised and channeled through government. This system made room for collaborative efforts but with the Ivorian authorities steering the ship. The government set up a crisis committee (Conseil National de Security) to conduct the activities around Ebola. This committee's mandate was however modified after the terrorist attack in Ivory Coast, in order to focus on security issues (BBC 2016).

On the fiscal governance front, the introduction of a real-time audit into the EVD management funds was an important governance development worth emulating. In Sierra Leone, the Ministry of Finance and Economic Development (MoFED) speedily seconded finance personnel to facilitate procurement processes during the EVD response management. By doing so they hoped that the systemic challenges thus identified would be rectified during the following months, eventually leading to a reduction in the number of queries raised in annual audits.

While international partners continue to play a significant role in bolstering governmental efforts to curb the outbreak, it is extremely important that they realise their key role is supportive. Their support for the government and people of Sierra Leone should not include any activities that might undermine the government's authority (Westafricainsight).

Furthermore, the introduction of emergency hotlines for reporting probable and infected EVD cases was a game changer in the EVD response. Governments should invest in and continue to implement this initiative to promote community reporting and response mechanisms.

It can be seen that the EVD response exposed weak governance structures, estranged relationships between citizens and authorities, and the lack of commitment by governments and inter-governmental agencies to invest in emergency preparedness. It became glaringly obvious that promoting democratic accountability during complex emergencies can be very daunting and at times impossible.

OSIWA's Response

Let me end by sharing my organisation's contribution to the EVD. The Open Society Foundation and its regional body, the Open Society Initiative for West Africa (OSIWA), supported several initiatives aimed at the efficient and effective delivery of health services in the region with a focus on the governance systems. The EVD provided us with the unique opportunity of renewing our commitment to citizen-driven partnerships and engagements. We provided grants to several government and community-driven initiatives across the sub-region. These are particularly for the most affected MRU, to ensure that ordinary citizens, most often in the rural areas, take centre stage in the response efforts. Our grants to over 15 civil society organisations across the region were instrumental in providing IPC support to international and government-led structures and systems. Some of these grants include support to the only policy-driven platform to raise issues of accountability in the midst of a critical health emergency.

Conclusion and Policy suggestions

By the time WHO terminated the Public Health Emergency Concern (PHEIC) on 29 March 2016 (WHO 2016), governments in West Africa and indeed around the world had amassed significant experience about the EVD. This included the need to implement efficient, effective measures to bolster governance and health structures. The various post-Ebola recovery plans developed by the most affected countries provide a platform for the development of resilient health systems. However, building robust systems requires strong political will, resources and donor buy-in.

Notwithstanding the litany of criticisms levied against the UN, bilateral regional bodies and other donor agencies for their delayed response, the humanitarian support to the MRU countries during the EVD outbreak contributed significantly to the eradication of the scourge.

While the EVD epidemic had dire implications for the MRU, it is glaringly obvious that democratic accountability was put to the test during the EVD outbreak. For governments to respond effectively to humanitarian crises, governance institutions should remain accountable, the rule of law and human rights must thrive, and robust and implementable policies must be promoted.

The following recommendations are proffered based on experience in tackling the EVD epidemic:

- Respective governments should invest in the effective functioning of disaster management institutions with innovative budgetary and fund-raising approaches to ensure constant availability of resources for such institutions.
- The MRU governments should establish and institutionalise the effective operation of a decentralised national health service that includes an ambulance service.
- Where trust and confidence between the citizens and the ruling elites is broken at both national and sub-national levels, governments should develop programmes that promote public participation and ownership of development initiatives, and introduce innovative information collection and dissemination to regain the trust and confidence of its citizens.
- Governments should develop health sector reform programmes that include management

information systems and donor coordination for programme alignment with government priorities.

- Governments should establish robust, transparent and accountable mechanisms to coordinate internal and external resources during emergencies.
- The WHO, AU, ECOWAS and MRU should set aside funds for capacity building for health management personnel to ensure an effective response to natural, health and man-made disasters. Innovative private-public partnerships could be pursued to ensure the sustainability of such an initiative.

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About EISA

Since its inception in July 1996 EISA has established itself as a leading institution and influential player dealing with elections and democracy related issues on the African continent. The organisation's Strategic Goals are:

- Electoral processes are inclusive, transparent, peaceful and well-managed;
- Citizens participate effectively in the democratic process;
- Political institutions and processes are democratic and function effectively; and
- EISA is a stronger and more influential organisation

The vision of EISA is "an African continent where democratic governance, human rights and citizen participation are upheld in a peaceful environment". This vision is executed through the organisational mission of "striving for excellence in the promotion of credible elections, participatory democracy, a human rights culture, and the strengthening of governance institutions for the consolidation of democracy in Africa".

Having supported and/or observed over 100 electoral processes in Africa, EISA has extensive experience in formulating, structuring and implementing democratic and electoral initiatives. It has built an internationally recognised centre for policy, research and information and provides this service to electoral management bodies, political parties, parliaments, national and local governments and civil society organisations in a variety of areas, such as voter and civic education and electoral assistance and observation. Besides its expanded geographical scope, the Institute has, for the past several years, been increasingly working in new in-between election areas along the electoral and parliamentary cycle, including constitution building processes, legislative strengthening, conflict management and transformation, political party development, the African Peer Review Mechanism (APRM) and local governance and decentralisation.

EISA provides technical assistance to inter-governmental institutions, such as the African Union, the Pan-African Parliament and Regional Economic Communities (RECs), to reinforce their capacity in the elections and democracy field. The Institute has signed Memoranda of Understanding with the African Union (AU), the Economic Community of Central African States (CEEAC); the East African Community (EAC); and the Common Market for East and Southern Africa (COMESA). EISA also works on an ad hoc basis with the Southern African Development Community (SADC) and the Economic Community of West African States (ECOWAS).

EISA has current and former field offices in Angola, Burundi, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Egypt, Gabon, Kenya, Madagascar, Mali, Mozambique, Rwanda, Somalia, Sudan, Zambia and Zimbabwe.

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