

Integrated Health Governance and Sustainability: Rebuilding Livelihoods and Resilience in Post-Ebola Communities in West Africa*

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Introduction

The recent Ebola epidemic in Guinea, Liberia, and Sierra Leone reveals the weaknesses of the health infrastructure in these countries. The outbreak and rapid spread of the disease in late 2014 and early 2015 in West African countries also highlighted the importance of global migration in an emerging borderless world. But more importantly, it reminded us of two significant aspects of global health security and preparedness, which demand immediate attention. First, the Ebola Virus Disease (EVD) outbreak reminds us of the interlocking nature of the socioeconomic determinants of health, especially within the context of sustainable development in poor and under-served communities in Africa. Second, the outbreak highlights the need to organize and finance global health emergency response systems differently from the present ad hoc strategy. Human societies have become more interconnected through globalization driven by increasing flows of goods, services, capital, people, technologies, information, ideas and labour across borders. Yet, the outbreak of the EVD would not have been declared an international public health emergency, if it was properly controlled and managed at its point of origin.

The Ebola Outbreak in West Africa

The EVD outbreak revealed that collaboration across existing governance regimes could strengthen the integration of health concerns into the wider development agenda. The

current outbreak of the EVD can be traced back to the remote village of Méliandou in Gueckedou prefecture, a major regional trading center in Southern Guinea in late December 2013¹. The Ebola epidemic spread to neighbouring Liberia, Sierra Leone and other seven countries ultimately by land and air travel. Before the end of March, the EVD had spread across the border into Liberia, and reached Sierra Leone in May of the same year. The spread of the disease to Nigeria in July was brief, as it was rapidly controlled; hence, the impact was mild and tactfully managed compared to the worst affected countries in the region.

Impacts of the EVD The impacts of the recent outbreak of the EVD fall far beyond the health sector. The epidemic damaged the socioeconomic fabric of the societies that were mostly affected in the three West African countries. Prior to the outbreak, the three countries that were at the epicenter of the crisis were already considered among the poorest countries in the world, and they had the lowest human development indicators. Thus, the populations in these countries were already at risk: food-insecure, lacking access

¹ The first outbreak of EVD was reported in the village of Yambuku in the former Zaire (current Democratic Republic of Congo) in 1976. The disease was first identified and investigated by a Belgian scientist Peter Piot, now Director of the London School of Hygiene and Tropical Medicine. *UNDG (2015) Socio-Economic Impact of Ebola Virus Disease in West African Countries. February 2015.*

to basic medical care, proper sanitation, productive employment, livelihood opportunities and inclusive growth². However, the outbreak of the EVD decimated the fragile health sector in the most affected countries. Figures from the World Health Organization (WHO) show that the Ebola outbreak in Guinea, Liberia, and Sierra Leone infected an estimated 28,637 people and claimed the lives of 4,809 people in Liberia, 3,955 in Sierra Leone, 2,536 in Guinea, and 8 in Nigeria. A total of 11,315 deaths were caused by the EVD in West Africa³. The total number of reported Ebola cases is about 28,637⁴. In addition, the EVD outbreak caused substantial economic losses and disruption to the means of livelihoods.

Weak Health care Infrastructures and the Ebola Outbreak

The rapid spread as well as the overall impact of the EVD in West Africa illustrates that national and local systems and health infrastructures were ill-prepared and for the most part, non-existent, to deal with the Ebola epidemic. For this reason, the vulnerability of both individuals and communities were made more pronounced across the region. The implication is that there was a sudden increase in demand for essential health services, which overreached the available health infrastructure. The diversion of all health resources to meet the heightened demand created by the Ebola outbreak rendered health institutions and facilities incapable of addressing other illnesses such as maternal and child health services, malaria, and tuberculosis (WHO, 2012). The spread of Ebola within a short period of time highlights the absence of an

integrated health care delivery system, which exacerbated the impact of the disease.

At the outbreak of the epidemic, the major socioeconomic determinants of health, such as the capacity of health infrastructure in the three epicenters of EVD in the region, were severely incapacitated and non-functional in many instances. This hindered the coordinated and swift response to the outbreak. Many development agencies such as the United Nations Development Programme (UNDP) and the World Health Organization (WHO) that responded immediately after the outbreak identified a number of challenges. For instance, they highlighted the inadequate number of qualified health personnel, as well as the apparent weakness of supporting infrastructure, logistics, health information, surveillance, low health expenditure, and inadequate drug supply. As Kieny *et al* (2014) espoused, the lack of balanced investment in the health system created an unsustainable health infrastructure, which rendered the organization and management of health services in these countries during the EVD outbreak sub-optimal. This, in turn, made the initial control and treatment of the EVD extraordinarily challenging.

Resilient and Sustainable Health System in Post-Ebola Communities

Generally, the reduction in a county's vulnerability to health risks, such as to the recent Ebola outbreak, depends largely on the availability of vital systems and infrastructures or what the Commission on Social Determinants of Health (2008) referred to as the socioeconomic determinants of health. These elements are comprised of circumstances in which people are born, live, work, grow, age, and the systems put in place to deal with illnesses in the community (ibid).

² UNDP and Partners (2015) Recovering from the Ebola Crisis

³ WHO (2015a) End of Ebola transmission in Guinea. Geneva, December 19, 2015

⁴ ibid

At the same time, these factors underscore the level of preparedness of each country to resist an outbreak in the magnitude of the EVD, and create a resilient and sustainable health system.

Sustainable Global Health Response Structure

Obviously, effective response to global health emergencies depends on sufficient funding and preparedness. However, many advanced countries, international development organizations and UN agencies request and dispense health emergency funding on a disease-by-disease (case-by-case) basis. Unfortunately, this strategy delays action and eventually costs lives. As Glass (2016) rightly argued, cross-border viruses such Ebola and the more recent one, Zika, are not unpredictable emergencies. Instead, these health issues are near certainty. What remain uncertain are the exact pathogen, timing, origin and scale of occurrence of viruses. However, the response of the global community has always been reactionary rather anticipatory. Against this backdrop, it has become imperative to design an integrated and permanent global health emergency response system.

This strategy will entail building an integrated global health emergency workforce. This will build on lessons from previous health emergency responses, particularly the EVD outbreak in West Africa⁵. From the perspective of health delivery, this system will be similar to WHO's Global Foreign Medical Team Registry, which sets minimum standards for international health workers to enable teams to clearly outline their services and skills (WHO, 2015b). In addition, this system

will link national health authorities with global health responders, and ensure that such responders have appropriate skills and local knowledge. The WHO's roster of foreign medical response teams allows for easy deployment of health workers during health emergencies. Furthermore, global health emergency preparedness should incorporate social and economic determinants of community health and resilience (i.e., non-health elements of health). Among these elements are circumstances centered on rebuilding livelihoods (such as economic growth, employment creation and social cohesion), health care infrastructure and better resilience capabilities. A permanent global health emergency system will enable health and development teams to provide care in a prompt manner to the people during crisis and in post-crisis times. This arrangement will facilitate a more robust response system and a better coordination between aid providers and health service recipients. This is essential because the fallout from the global health emergencies such as the Ebola outbreak in West Africa and the Zika outbreak in Southern America will be manifested more within the livelihoods of communities.

Conclusion: Building on the Efforts of Development Agencies

Although Guinea, Liberia and Sierra Leone have been declared "Ebola Free" countries, more remains to be done in rebuilding and reintegrating communities to the level where they can resist future health shocks. Despite the delay, the overall response of the international community to the EVD outbreak in West Africa remains commendable. Under the auspices of the UNDP, key interventions have been put in place to restore livelihoods and build sustainable communities in the post-Ebola West Africa. UNDP's development

⁵ WHO coordinated the deployment of nearly 60 foreign medical teams provided by 40 organizations. It was the first time that foreign medical teams were deployed during an outbreak (WHO, 2015b).

interventions in the aftermath of the EVD outbreak aims to both stabilize communities and livelihoods in the short-term, and lay the foundations for resilient and sustainable development over the longer term. Such interventions include the provision of social protection measures, especially social cash transfers to the families of Ebola victims and survivors in Guinea and Sierra Leone (Global Ebola Response, 2015). Others include livelihood and economic recovery through job creation initiatives and the rebuilding of infrastructure and sustainable waste management in Guinea and Liberia. However, as economic growth rebounds in the region, the current challenge is how to sustain the progress made, ensure continuity, and develop and implement strategies to make health systems and infrastructure in the region stronger and resilient.

References:

WHO (2008) *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health.

Glassman, A. (2016) *Another Emergency Funding Request for Global Health. Can't we Do Better?* Center for Global Development. (Retrieved on February 12, 2016 from <http://www.cgdev.org/>)

Global Ebola Response, (2015) *Interagency Collaboration on Ebola Situation Report No. 11*. UNDP Liberia - UNDP Support to the National Ebola Response

Kieny, M, Evans, D.B, Schmets, G & Kadandale, S. (2014) Health-system resilience: reflections on the Ebola crisis in western Africa. *Bulletin of the World Health Organization* 92:850.

WHO (2012) *Strengthening Health-system Emergency Preparedness: Toolkit For Assessing Health-System Capacity*. Part 1 User Manual.

WHO (2015a) *End of Ebola transmission in Guinea*.

WHO (2015b) Building a global emergency workforce ready to go.