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From Security to Stability: Health Interventions in Fragile and Conflict Affected Settings.

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Executive Summary

In 2023, fragile and conflict-affected states (FCAS) received 52% of total DAC-allocable aid, yet they continue to exhibit some of the world's weakest health systems and poorest health outcomes. With aid budgets projected to decline by 9-17%, understanding which health interventions most effectively strengthen health system resilience, and whether these gains contribute to broader sociopolitical stability, has never been more urgent. This report examines four health interventions in Guinea, Ethiopia, Burundi, and Sierra Leone to assess:

1. *To what extent do different types of health-focused aid interventions in FCAS strengthen health system resilience?*
2. *And how does improved resilience influence sociopolitical stability in these contexts?*

Using a process-tracing methodology, the study draws on 14 semi-structured interviews with humanitarian workers, government officials, and health practitioners, alongside organisational reports and secondary data. The findings show that health-focused aid can strengthen the resilience of health systems in FCAS, but outcomes remain uneven and highly dependent on political conditions, crisis phase, and the degree of local ownership embedded in interventions. While absorptive and adaptive capacities can emerge during active crises, long-term transformative change requires functioning governance, sustained financing, and local ownership.

Even partial fulfillment of these conditions demonstrates that strengthened health systems can contribute to sociopolitical stability, primarily through reinforcing the social contract. Visible, equitable, and locally embedded service delivery can strengthen trust in institutions and reduce grievances. Cases such as Sierra Leone's Free Health Care Initiative and Burundi's Village Health Works illustrate how politically supported and community-based approaches can improve both health outcomes and social cohesion, while also highlighting the fragility of these gains when donor funding or political commitment declines.

Across all cases, interviewees consistently resisted framing health as a direct driver of peace. Instead, health emerged as a prerequisite for stability. According to them, it is a foundational condition that enables the social and political processes through which peace is built, rather than a mechanism that produces peace on its own.

Based on these findings, the report proposes the following recommendations:

1. **Political Will**
    a. Health promotion campaigns should be co-designed with community and religious leaders to ensure messages are clear, locally grounded, and trusted.
    b. Visible, neutral, and agnostic service delivery must be protected as a foundational principle, ensuring that access to care is never instrumentalised for political ends.

2. **Fragility of Funding**
    a. A dedicated portion of every health intervention's budget should be earmarked for health system strengthening to reduce structural vulnerability beyond the emergency phase.
    b. Exit strategies must be built into intervention design from the outset, prioritising diversified and blended financing structures over sole dependence on external donor funding.

3. **Local Ownership**
    a. Community-led health surveillance should be embedded within national frameworks, ensuring that grassroots engagement drives early detection and response from the bottom up.
    b. Local workforce training and infrastructure development must be prioritised to build sustainable capacity that persists after international actors withdraw.
    c. Decentralisation of health workforce and infrastructure distribution is essential, ensuring that nationally integrated responses are adapted to sub-national contexts rather than defaulting to centralised delivery.
    d. Knowledge sharing across the local health landscape should be systematically fostered, enabling facilities, staff, and communities to build on each other's capacities.

4. **Coordination**
    a. A defined central coordinating actor, ideally the Ministry of Health, should be identified from the outset, with consolidated, multisectoral coordination across all actors to avoid duplication, competition, and gaps in coverage.

Introduction

Since the end of the Cold War, new forms of conflict, especially internationalized violence and terrorism, have become increasingly common, creating instability that can spread across borders (Brown & Grävingholt, 2016). Poverty, weak economies, unemployment, and poor governance have created conditions in which marginalized individuals are more easily recruited into violence (Zoellick, 2008). Such environments are often described as fragile. The World Bank (2025a) defines fragility as extremely low institutional and governance capacity that undermines a state's ability to function, maintain peace, and support development. Countries meeting these criteria are classified as Fragile and Conflict-Affected States (FCAS). The World Bank estimates that within the next decade, 400 million people living in extreme poverty will reside in fragile contexts (World Bank, 2025b). Although fragility and conflict are distinct, they reinforce one another (Desai, 2020, p. 11). Fragile settings are also highly vulnerable to humanitarian crises, including conflict, epidemics, famine, and natural disasters, which leave populations in urgent need of basic assistance such as shelter, food, water, and healthcare (Humanitarian Coalition, 2024).

In the international arena, FCAS are seen as especially concerning because they lack the capacity to provide basic public goods and their instability can spill over through terrorism, migration, and organized crime. As a result, they receive a large share of global development assistance, 52% of total DAC-allocable aid in 2023 (OECD, 2025a). Yet aid effectiveness in fragile contexts remains limited, as fragility itself creates a vicious cycle that external actors rarely overcome (Zürcher, 2025, p. 48). At the same time, aid budgets are shrinking, with the OECD (2025b) projecting a 9-17% decline from 2024. This makes it crucial to identify which types of interventions and sectors are most likely to succeed in fragile settings.

FCAS tend to have the weakest health systems and the poorest outcomes, with distorted basic health indicators, limited access to essential services, and insecurity that severely hinders health delivery (Bogale et al., 2024). Conflict and fragility create new disease burdens while existing needs persist, and disruptions to care worsen chronic and non-communicable conditions, increasing morbidity and mortality, especially during protracted or recurrent crises. Crucially, inadequate access to health and basic social services is not only a consequence of conflict and displacement but can also help sustain them (IOM, 2021; WHO, 2025). Rising socioeconomic inequalities further fuel political instability by intensifying grievances within and between groups (Justino, 2025, p. 3). Addressing health needs in FCAS therefore requires long-term strategies that tackle the structural drivers of fragility and conflict.

Despite the recognised importance of health interventions in FCAS and the development of various organisational frameworks, health is still largely treated as an outcome rather than as a potential driver of stability.

Research Objectives

The evidence base on how health investments contribute to reduced fragility remains limited, particularly regarding whether specific forms of support, such as financial aid structures or long-term commitments, translate into measurable improvements in stability (Haar & Rubenstein, 2012, p. 297; Gordon, 2013, p. 35). Existing literature also pays insufficient attention to how differences in the design of health interventions, especially the extent to which they are linked to state institutions, may shape stability outcomes (Percival, 2017, p. 80). Furthermore, many analyses overlook the interactions between multiple healthcare providers and the effects of parallel service-delivery systems, both of which may influence resilience and governance dynamics (Truppa et al., 2024, p. 2). Lastly, as Bogale et al. (2024) note, much of the existing literature on health system strengthening in FCAS remains focused on challenges and interventions during active crises and the early recovery phase, leaving longer-term system development interventions comparatively understudied (p. 27). In light of these gaps, this report examines the following questions:

To what extent do different types of health-focused aid interventions in FCAS strengthen health system resilience?

And how does improved resilience influence sociopolitical stability in these contexts?

The report will proceed as follows. First, it will review the existing literature and theoretical debates on the relationship between health interventions and stability in FCAS. The report will then outline the proposed methodology for examining the research question, along with its anticipated limitations. Following this brief introductory framework, four case studies will be examined, offering specific recommendations for each. Finally, common themes across the case studies will be synthesised into final conclusions and general recommendations.

Literature Review

This report acknowledges the broader framing of *situations of fragility* compared to *fragile states,* recognizing that fragility is not solely determined by state structures or borders, and that understanding and addressing it requires examining societal conditions as a whole, beyond the state itself (McLoughlin & Idris, 2016, p. 6). Thus, throughout this paper, the terms *situations of fragility* and *FCAS* will be used interchangeably, given many of the mechanisms discussed are closely linked to building trust and strengthening the social contract with institutions, which are key pathways to reducing fragility. Understanding how fragility is conceptualized is essential before turning to the practical question of how aid functions within these contexts.

Aid effectiveness in FCAS

To begin this review, it is essential to outline the main debates about which aid interventions work best in FCAS, starting with the concept of human security. Following the Cold War, the concept of human security broadened the focus of protection from states to individuals, encompassing poverty, violence and disease (CSS ETH Zurich, 2011). After 9/11, however, donor priorities shifted back toward their own national security, giving rise to the development-security nexus, the idea that

security enables development, and development sustains security (Zoellick, 2008; Dursun-Özkanca, 2021).

Scholars argue that a key issue in the development-security nexus is the securitization of development, whereby challenges in developing states are increasingly framed as security threats. In FCAS contexts, donor countries often approach aid through a risk-management lens, prioritising their own security concerns over long-term poverty reduction and sustainable development (Gebrezgabher, 2018; Denney, 2011). This logic also shapes global health interventions, with the Global South frequently portrayed as a source of disease threats (Youde, 2018). While securitizing health can raise political attention, mobilise funding, and accelerate action, as seen in the global response to HIV/AIDS, it also has important limitations (Elbe, 2006). Security-driven interventions tend to be short-term and vertical, often neglecting broader health system strengthening and potentially undermining community trust when programmes are perceived as serving external rather than local interests.

In fragile states, which often suffer from weak governance and limited institutional capacity, donors have tended to focus heavily on peacebuilding and democratization initiatives, and most of the funding has gone in that direction (Zürcher, 2025, p. 38). However, this approach has faced significant criticism. Zürcher points out that in countries like Mali, Afghanistan, and South Sudan, efforts to strengthen government capacity and promote good governance have often fallen short, especially when they clash with local political dynamics and entrenched patronage systems (pp. 39-40). Similarly, stabilization programs have generally done little to build trust between groups or improve government legitimacy (p. 41). One reason for these shortcomings is that legitimacy usually comes from effective service delivery, which is crucial for establishing a durable social contract (Zoellick, 2008, p. 73). In contrast, aid aimed at health, education, and other basic services tends to be more effective, since it focuses on delivering tangible, technical outcomes that can, over time, foster greater stability in fragile contexts (p. 42).

The Nexus of Health, Fragility and Stability

Building on these debates, this section examines how health system performance is intertwined with broader patterns of fragility and stability. Health systems in fragile and post-conflict settings operate under severe pressures, including economic instability, political turmoil, damaged infrastructure, insecurity, and shortages of health workers, all of which contribute to worsening population health (Haar & Rubenstein, 2012). These constraints make it difficult to pursue goals such as universal health coverage, particularly as funding remains limited and donors often place low priority on long-term system-building in FCAS (Martineau et al., 2017). At the same time, armed conflict increases disease burdens while disrupting routine service delivery, exacerbating chronic and non-communicable diseases and raising morbidity and mortality, especially in protracted crises (Bogale et al., 2024). In many fragile states, these pressures are increased by the reliance on unregulated local healthcare providers operating outside formal systems, reflecting weakened institutions, governance

failures, and the collapse of essential services (Thompson & Kapila, 2018).

In fragile settings, Social Determinants of Health (SDH) play a crucial role in shaping both population vulnerability and the capacity of health systems to respond to shocks. Conflict-driven disruptions to livelihoods, education, infrastructure, and community networks undermine the system's ability to absorb shocks and maintain service delivery, directly linking everyday socioeconomic conditions to health system performance (Aguirre et al., 2022; Singh et al., 2023).

In certain contexts, insecurity, poverty, and gendered restrictions, including limits on women's mobility and the loss of female health workers, further reduce access to care and deepen inequalities (Singh et al., 2023). Conversely, investments addressing the social determinants of health, such as access to services, financial protection, sanitation, energy, and community participation, can strengthen resilience by reducing vulnerability and supporting continuity of care during crises (Saraswathy, 2021). These interconnected factors illustrate how health interventions can generate broader stabilising effects on social and political dynamics. Across the literature, scholars widely agree that health is central to social stability (Labonté & Gagnon, 2010; Haar & Rubenstein, 2012; Gordon, 2013; Pattanshetty et al., 2023). In this sense, health assistance in fragile states is not only a humanitarian imperative, but also a strategy for strengthening the social contract by making the state more visible and relevant in people's everyday lives (Haar & Rubenstein, 2012; Gordon, 2013).

One key pathway through which health can support stability is by strengthening community trust through primary health care (PHC). PHC development can function both as a resilience strategy and a peacebuilding mechanism by linking health system strengthening to broader social and political stability. Visible improvements in access to services can reinforce perceptions of state capacity and commitment to the social contract, for example through the provision of basic health service packages (Witter & Hunter, 2017). Scholars also highlight that transformative peace can be fostered through integrated and community-based approaches that connect health promotion with peacebuilding initiatives (Christensen & Edward, 2015; Lilja & Ahmad, 2023; Ptacek & Connaughton, 2023). In addition, protecting health workers from violence and strengthening workforce resilience are essential for maintaining stability and sustaining health system functions in fragile settings (Truppa et al., 2024).

These insights have informed more formalised approaches which provide frameworks for linking immediate humanitarian response with long-term system strengthening and stability goals. When health services must be rapidly rebuilt after conflict or crisis, international agencies often step in to deliver essential care.

Health system resilience (HSR), defined as "the ability of the health system to plan and prepare for future crises and absorb, adapt, or transform to maintain its structure and functions when exposed to acute shocks or chronic crises", is critical to achieving these goals (Lilja & Ahmad, 2023, p. 1). During acute shocks, the surge in local service delivery supported by international actors may also fail to translate into long-term system strengthening (Ager et al., 2019, p. 378).

The unpredictable nature of crises introduces additional barriers that complicate and delay rebuilding efforts (Bogale et al., 2024, p. 3).

Critiques

Several critiques have been raised regarding *Peace through Health* initiatives. The most persistent concern is the limited evidence supporting their effectiveness; without robust assessment tools or empirical data, claims that health interventions can consistently foster peace remain contested (Rushton & McInnes, 2006, p. 105; Rahmani & Mohammadi, 2023, p. 275; Christensen & Edward, 2015, p. 54). Moreover, most health interventions do not explicitly articulate stabilization or broader state-building goals. Instead, any contributions to peace or stability often appear as unintended, while efforts are primarily aimed at improving health outcomes (Gordon, 2013, p. 36).

Critics also warn that PtH initiatives could unintentionally prolong conflict: by creating a fragmented, patchwork health delivery system, they may deepen inequalities or foster new grievances, characterised by vertical programmes and unsustainable standards or facilities, largely because post-conflict countries have limited institutional, technical, and managerial capacity (Rushton & McInnes, 2006, p. 95; Martineau et al., 2017, p. 2). Furthermore, although health is often framed as a universal public good, certain interventions can in practice be partially rival and partially excludable, providing uneven benefits and appearing to favour specific groups in a conflict (Percival, 2017, p. 80).

When health becomes intertwined with broader political agendas, this perceived bias can erode neutrality, exposing health workers to targeted violence and allowing programmes to be co-opted for political or strategic gain (Rushton & McInnes, 2006, p. 106; Christensen & Edward, 2015, p. 34). As a result, interventions may be resisted or disrupted significantly reducing the likelihood of achieving positive health outcomes. These risks are particularly acute for efforts to strengthen health system resilience, as intrastate conflicts frequently revolve around control of state institutions; initiatives that reinforce those institutions may therefore be seen as politically charged and, consequently, may not be tolerated (Percival, 2017, p. 82).

Public mistrust of state institutions in FCAS remains a major barrier (Atallah et al., 2018, pp. 102-103). Entrenched mistrust in state institutions weakens public health by driving communities to avoid government services, reject campaigns, and rely on unregulated alternatives from other providers.

Finally, health interventions that rely on NGOs as the primary providers of care often present this arrangement as a temporary solution until state capacity improves. However, such models can unintentionally sideline the state by reducing its role to that of a decision-maker rather than a direct service provider, thereby limiting the activation of mechanisms that build state legitimacy (Gordon, 2013, p. 34).

Methodology

This study employs a process-tracing methodology that combines the review of descriptive quantitative data, secondary sources, and qualitative interviews with key informants. The study aims to understand how the design and programming of health interventions influence health system strengthening and subsequent performance on key health indicators, and whether these gains have spillover effects on sociopolitical stability.

Independent Variable: Health Interventions

In this study, the independent variable is *health interventions,* which cover a wide range of programs that differ in type, scope, duration, and funding. This includes short-term, emergency-focused initiatives that respond to immediate crises, as well as long-term programs (both community and state-run) designed to strengthen the health system and build institutional capacity.

Mediator: Health System Resilience (HSR)

Health System Resilience is incorporated as a mediating variable to understand the mechanism by which interventions translate into sociopolitical stability. HSR captures how well the health system can maintain services, respond to crises, and serve communities fairly and reliably. Emphasis on the system's overall capacity and adaptability makes HSR a key factor in explaining broader stability effects. An overview of the indicators used is in the appendix.

Dependent Variable: Sociopolitical Stability

The dependent variable in this study is *sociopolitical stability*, considered both as an outcome of health interventions and as a result of strengthened health systems. For this study, we will measure sociopolitical stability through *trust in institutions* and *social cohesion/intergroup relations*. An overview of the indicators used is in Appendix A.

Data Collection and Evaluation: Process-tracing

The process-tracing proceeded in several steps. First, baseline indicators of health outcomes prior to the intervention were assessed. Next, qualitative interviews, descriptive data and project documents were used to evaluate the intervention's effectiveness in strengthening health system resilience and improving health outcomes, analysing key quantitative and qualitative indicators. Finally, through interviews, the study assessed how the intervention may have influenced sociopolitical stability, taking into account the different dynamics of the intervention's design and programming. Information gathered in interviews was coded to reflect the effectiveness of each health intervention.

Limitations

In relation to the report's methodology, the following limitations are to be acknowledged. First, although this research seeks to identify the mechanisms that may operate within health interventions in FCAS, it does not claim that these interventions are uniformly effective or that they follow a single predictable pattern.

Measuring effectiveness in such contexts is notoriously difficult, given the complexity and volatility of fragile environments. The aim, therefore, is not to assert that all interventions will behave in the same way, but rather to trace the possible pathways through which health interventions might contribute to broader outcomes. Second, when using interviews and assessing sociopolitical stability through health workers' perceptions, there is a risk of recall bias, subjective interpretation, or affiliation bias, since participants were directly involved in the programs. To mitigate this, we included interviewees from multiple organizations to capture diverse perspectives and reduce potential biases, and we will triangulate data with secondary sources to fill gaps. Finally, although our partner can connect us with many stakeholders, the specific interviewees have not yet been confirmed. As a result, we needed to reassess our selection of case studies depending on who is ultimately available.


Photo by Village Health Works, November 2025 / https://www.instagram.com/villagehealthworks/.

CASE STUDIES

The selected case studies represent interventions implemented in states that were classified as FCAS at the time. They were chosen for their geographical proximity and the diversity of planning modalities, which allows for a comparative analysis of how different approaches affect outcomes. Additionally, these interventions are well documented in both the literature and project records, facilitating a more detailed and in-depth examination.

We understand that the accuracy of data in conflict and post-conflict settings may be challenging to corroborate, therefore this report sought to use multiple sources to assess the available indicator data.

Health workers walk inside a new graveyard for Ebola victims, on the outskirts of Monrovia, Liberia on March 11, 2015. Abbas Dulleh—AP

GUINEA

EMERGENCY MEDICAL RESPONSE

Historical Context

Between 2013 and 2016, West Africa experienced the Ebola virus outbreak, a highly lethal hemorrhagic fever that the World Health Organization described as *the most severe acute public health emergency in modern times* (Wilkinson & Leach, 2014, p. 136). The epidemic resulted in 34,356 reported cases and 14,823 deaths across 11 Sub-Saharan African countries, with rapid transmission facilitated by densely populated urban and rural areas (Ohimain & Silas-Olu, 2021, p. 360). Guinea was among the countries most severely affected and is widely considered the origin point of the outbreak. The country's vulnerability was shaped by a broader history of political instability and regional conflict. Throughout the 1990s, civil wars in neighbouring Sierra Leone and Liberia led to significant population displacement, with large numbers of refugees settling in Guinea's Forest region (McPake et al., 2015, p. 1).

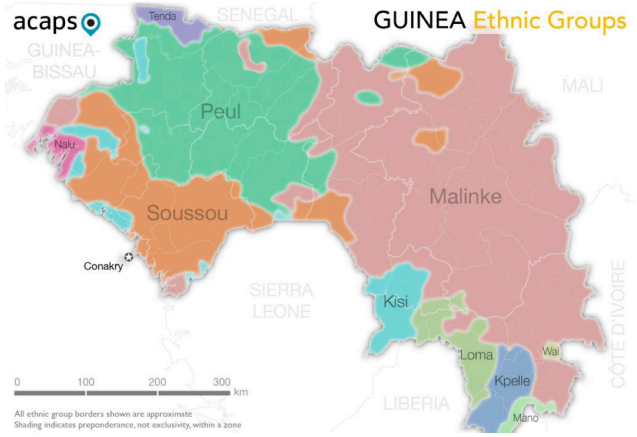

Figure 1. Guinea: Country Report. ACAPS (2015).

Despite the formal transition to elected governance, underlying tensions persisted, with intercommunal violence between the Malinké population and autochthonous groups in Guinée Forestière resulting, in 2013 in more than 200 deaths (International Crisis Group, 2014, p. 13). Intercommunal divisions remain a central feature of Guinea's political landscape as well. Reflecting these structural and political fragilities, Guinea was ranked 12th on the Fragile States Index in 2014 (Fund for Peace, 2024)

The State of Health

In Guinea, the main organisations leading the response were the Guinean National Ministry of Health, WHO, MSF, IOM, ICRC, CDC, and UNICEF. The outbreak was officially declared by the Guinean Health Ministry on the 22nd of March 2014, although it is believed that the virus had been circulating undetected since December, particularly since by March there were already around 200 cases spread across different regions of the country (MSF, 2016, p. 7).

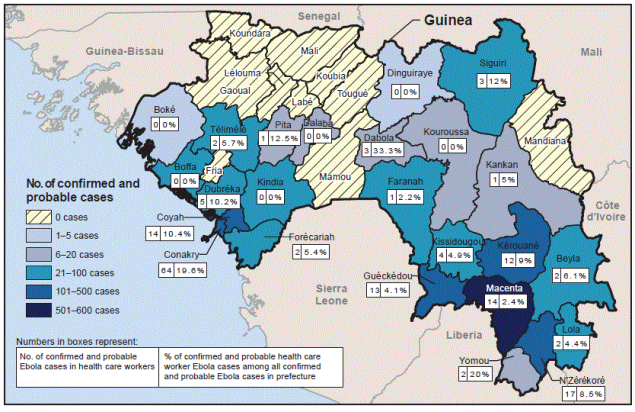

Figure 2. Ebola Virus Disease in Health Care Workers - Guinea, 2014. CDC (2015)

The health system was strongly affected by the country's unstable political and economic context, with approximately 65% of healthcare costs being paid directly by patients and very limited infrastructure and health workforce capacity (International Crisis Group, 2015, p. 7). This structural weakness significantly reduced the ability of the system to detect and respond

rapidly to the outbreak. In terms of logistics, interviewees reported that at the beginning of the response there were only four national vehicles available. As a result, many people had to walk or take taxis to reach treatment centres, which increased the risk of infection and contributed to further spread of the virus. Furthermore, Guinea faced a major shortage of trained health personnel, particularly doctors and epidemiologists. At the start of the response, WHO had to recruit university students to help fill urgent workforce gaps, while early cases were frequently misdiagnosed with other diseases such as cholera. In addition, there was no structured data management or reporting system in place, which meant that the Health Information System lacked the capacity to properly coordinate surveillance and track the evolution of the outbreak.

Results/Findings

Health System Strengthening

The Ebola response in Guinea contributed to a significant expansion of the national health infrastructure, including the establishment of Ebola Treatment Centres (ETCs) and the development of Primary Health Care (PHC) units in areas where they previously did not exist. Interviewees underscored that these treatment centres were later reused during the subsequent measles epidemic, which emerged following a decline in Measles vaccination coverage during the Ebola period, and again during the Ebola outbreak in 2021. Although these centres were not always fully functional and at times lacked essential supplies, it reportedly took less than a few days to reactivate them during the later outbreak, compared to the much slower initial mobilisation during the first epidemic. Some interviewees, however, raised concerns about both the quality and long-term sustainability of these facilities in the post-Ebola period. Concerns about quality focused on how triage and accessibility issues were designed and managed, while concerns about sustainability related to the lack of running water and basic infrastructure in some centres, as well as the limited durability of the facilities.

In terms of the health workforce, interviews highlighted that the Ebola epidemic contributed to training a generation of healthcare professionals in Guinea. Through programmes such as those led by IOM and WHO, local doctors and heads of primary health centres received capacity-building, and many of those who joined the system during the response were later retained in primary health centres. However, maintaining staff presence remained a major challenge. During the outbreak, many health workers were redeployed from PHCs to ETCs and then moved back afterward, leaving ETCs frequently understaffed and difficult to run continuously. This was especially evident in Guéckédou, where only about 50 healthcare workers were formally paid and others worked as volunteers, sometimes charging patients for services, while the situation appeared less severe in Conakry. An interviewee also noted a post-Ebola initiative that deployed newly graduated doctors to clinics across the country to improve geographic coverage, although this programme has since been discontinued. Overall, the interviews highlighted that producing and retaining doctors and nurses requires long-term investment, not only in training but also in ensuring stable conditions that encourage them to remain in the country.

A key outcome of the Ebola response in Guinea was the development of a strengthened health surveillance system. Interviewees highlighted the establishment of a community-based surveillance approach, designed to complement facility-level screening by capturing cases among individuals who do not access formal healthcare. This model was later institutionalised through a National Directorate for Community Health within the Ministry of Health. Although centrally coordinated, implementation was decentralised at community level, with trained volunteers across districts responsible for monitoring and reporting cases. Initially focused on Ebola, the system was later expanded to cover five priority epidemic diseases. Its main ongoing functions include disease surveillance, hygiene promotion, provision of basic care, and support for vulnerable groups such as pregnant women.

The Ebola outbreak had mixed effects on PHC utilisation. At the onset of the epidemic, health-seeking behaviour declined sharply as facilities were widely perceived as high-risk sites for transmission. This, combined with the redeployment of health workers to emergency response roles and the suspension of routine services such as vaccinations, reduced access to basic care and indirectly contributed to the spread of other diseases. In the later stages, however, community mobilisation efforts helped rebuild trust and increased engagement with PHC services, leading to higher utilisation. Additionally, because many epidemic symptoms overlap with common illnesses, strengthened community surveillance improved the reporting and detection of conditions such as malaria.

A key challenge highlighted was the sustainability of post-emergency funding. In many cases, funding was primarily directed towards crisis response rather than long-term systemic strengthening aimed at reducing future outbreak risk. One interviewee noted that the phone credits provided to community volunteers amounted to a budget comparable to that of the Ministry of Health itself, underscoring the importance of carefully designed exit strategies to ensure long-term sustainability beyond the emergency phase.

Discussion

Community impacts

At the start of the response, there was strong resistance toward the disease and health workers. This was driven both by the high fatality rate of Ebola and early communication emphasising the lack of effective treatment, which together fuelled fear and uncertainty. Burial practices were a major point of tension, as the introduction of *safe burials* conflicted with established cultural and religious norms. Over time, this led to greater community engagement, including closer collaboration with religious leaders to promote safer and more culturally acceptable burial practices.

The response also had some unintended effects on community trust in health institutions. Improvements in data management systems, including the introduction of solar-powered computers, indirectly influenced health-seeking behaviour. In particular, access to electricity at night increased the number of women attending health facilities for childbirth during nighttime hours. However, trust in ETCs remained limited, largely due to their design. Interviewees pointed out that features such as fencing and highly securitised layouts contributed to community reluctance to fully trust these facilities. Overall,

this was seen as reflecting insufficient contextual adaptation in the design and construction of the centres, highlighting the need to avoid a one-size-fits-all approach in future health infrastructure planning.

Community surveillance played a central role in strengthening engagement between health systems and local populations. Initially, community health workers were recruited from among responders and were paid, which in some cases led to perceptions of *Ebola business,* as well as grievances linked to selection processes and payment structures. At the same time, the epidemic had severe socioeconomic impacts, disrupting livelihoods and cross-border trade due to movement restrictions and border closures. Over time, the approach shifted towards greater community ownership, with local leaders involved in selecting volunteers to carry out surveillance activities on a non-remunerated basis. This transition strengthened local ownership and, through training and simulation exercises, also contributed to increased community cohesion. The involvement of Ebola survivors in ETCs further supported mobilisation by helping to build trust between health services and affected populations. In addition, theatre performances featuring well-known actors were used for sensitisation, contributing to wider public awareness and reinforcing collective engagement with the response.

A further key theme was the strengthening and nationalisation of service provision across the country. The response reached 26 of 33 prefectures, with affected areas covered under a unified national emergency framework. While one interviewee suggested that transmission patterns appeared to follow political and ethnic lines, with Fulani populations reportedly less affected than others, services were nonetheless delivered on an equal basis, as the outbreak was treated as a national emergency. It was also noted that there were instances of negative political communication directed towards the Forest region, particularly linked to perceptions of resistance from certain communities. However, despite these dynamics, service delivery remained uniform across affected areas.

State-Building Legitimacy Impacts

The Ebola response in Guinea also had important implications for state legitimacy and state-society relations. Several interviewees emphasised that the state's capacity to manage the outbreak, particularly through early communication framing Ebola as highly lethal, ultimately strengthened public trust in national institutions and their ability to respond to crises. This was reflected in the post-epidemic period, with one interviewee noting that the government's performance during the health emergency was positively rewarded in the 2015 political elections. Furthermore, although the state operated in a context of fragility, intense international scrutiny and crisis conditions increased pressure for visible responsiveness, making certain state actors more engaged and reactive to population needs. However, the strong imperative to *defeat Ebola* also created challenges, particularly competition for visibility between international actors as well as between domestic actors. In addition, international scrutiny reportedly led to tensions in reporting practices, with health workers in some facilities being discouraged from fully reporting case numbers.

The role of external partners in relation to state-building was mixed across interviews.

Some respondents highlighted significant regional variation in service provision, particularly in the early phase of the response. For example, MSF-run facilities were often better equipped and provided free care, while national health centres were slower to respond and offered a different standard of service. The early response was also characterised by fragmentation and weak coordination among actors, largely reflecting limited state capacity to effectively lead and organise the response. Interviewees described this period as a *plant-the-flag* dynamic, with organisations competing for geographical coverage as funding flowed in. This may have contributed to the underutilisation of the Guinean Red Cross, which one interviewee identified as a missed opportunity. Over time, coordination mechanisms improved and many organisations shifted towards more explicit capacity-building support for national institutions. However, MSF was still described as relatively autonomous and somewhat outside the broader coordination framework.

Lastly, the state's approach evolved significantly over the course of the response. In the early stages, the management of Ebola was characterised by a relatively high degree of securitisation, with some instances of coercive enforcement measures. One interviewee reported cases of arbitrary arrests and coercive behaviour towards a family during operations involving the army for security purposes, although most respondents suggested that such practices were less widespread compared to other contexts such as Sierra Leone. Over time, however, the response shifted towards a more community-centred approach, particularly through the nationalisation of the community health surveillance system. This transition contributed to greater inclusion of local actors in decision-making processes, which in turn enhanced perceptions of transparency and strengthened trust in state institutions through more shared governance.

A key theme emerging from the interviews is the relationship between fragility and the effectiveness of external assistance. It was suggested that the implementation of the humanitarian-development-peace nexus in highly fragile contexts may produce unintended consequences and, in some cases, generate more harm than benefit, particularly when state capacity remains limited and institutional foundations are weak. This is particularly impactful in the case of budgets for the health system, as the state may struggle to collect taxes and therefore increase its budgets for public services.

An injured resident of Togoga village arrives at the Ayder referral hospital in Mekele, the capital of Tigray region, Ethiopia, on June 23, 2021. Yasuyoshi CHIBA / AFP via Getty Images

ETHIOPIA

EMERGENCY MEDICAL RESPONSE

Historical Context

Ethiopia's history is one of war and conflicts. These conflicts are rooted in various ideological contexts, including religion, region, ethno-linguistic differences, and the selection of a sociopolitical paradigm, aimed at gaining power and controlling resources (Geda, 2004, p. 2). Political instability has been shaped by leaders who exploit ethnic identity to further their own agendas (Taye, 2017, p. 52). Consequently, different groups have developed competing political interests, and elites have found it difficult to find common ground or collaborate (Siyum, 2021, p. 20).

Leading up to 2018, for more than a century, two competing political approaches have shaped Ethiopia. One approach promotes a federal system based on the country's ethnic diversity, granting significant autonomy to different groups under a central government. The Tigray People's Liberation Front (TPLF) advanced this model, though it did not fully include other ethnic political actors while in power. The other approach, associated with Abiy Ahmed, who was elected Prime Minister in 2018, emphasizes a strong, centralized state based in Addis Ababa that aims to reduce ethnic conflict through national unity. In practice, however, this vision has had the opposite effect, contributing to deeper divisions and a worsening humanitarian situation (Pellet, 2021, p. 19).

Following Abiy Ahmed's rise to power, tensions with the TPLF escalated over the 2018 peace agreement with Eritrea. This agreement involved the acceptance of contested borders, as well as corruption trials targeting Tigrayan elites and the reorganization of the ruling coalition into the Prosperity Party, which the TPLF rejected. The conflict escalated in 2020 when national elections were postponed over concerns about the Covid-19 pandemic, the TPLF conducted its own vote in defiance of the federal government, and both sides declared each other illegitimate. This culminated in a complete political breakdown and ultimately led to armed conflict from November 2020 to November 2022 (Pellet, 2021, p. 12).

The Tigray war resulted in approximately 539,000 new displaced people, along with widespread human rights abuses, including sexual violence, and a significant increase in food insecurity. Furthermore, violence has also displaced individuals in the Afar Region, Amhara Region, Benishangul-Gumuz Region, and Southern Nations, Nationalities, and Peoples' Region, bringing the total number of new displacements nationwide to nearly 1.7 million, representing a 61% increase compared to 2019 (Internal Displacement Monitoring Centre, 2020). While Ethiopia was ranked 21st out of 179 countries in the Fragile States Index in 2020, it climbed to 11th place in 2021 and further remained highly ranked at 13th place in 2022 (Fund for Peace, 2024).

In November 2022 the Pretoria Peace Agreement was signed, yet the implementation remains incomplete. Recently, both sides have moved away from the Pretoria agreement, with the TPLF accusing Addis Ababa of failing to resettle 1.6 million displaced people and revoking its party licence, while the federal government faults the TPLF for failing to disarm and allegedly allying with Eritrea. So it seems that Peace has only been agreed to on paper but another escalation of the conflict might be looming (Lawal, 2025).

The State of Health

Ethiopia operates under a federal system, with responsibilities for healthcare delivery decentralized to regional governments, which led to variations in access, resources, and service quality across regions (Wamai, 2009). Beginning in the late 1990s, the government implemented the Health Sector Development Program (HSDP), a series of multi-phase strategies aimed at expanding primary healthcare, decentralizing services, and increasing the role of non-state actors. While these reforms contributed to the growth of health infrastructure and coverage, many targets were only partially achieved (p. 284).

From 2020, Tigray was under a de facto blockade, which severely limited humanitarian aid and essential supplies by restricting access to cash, fuel, telecommunications, and electricity. As a result, over 13 million people in Tigray, Amhara, and Afar required assistance. Malnutrition and outbreaks of diseases such as malaria, measles, and respiratory infections increased due to overcrowded camps, poor sanitation, and limited access to clean water (WHO, 2022).

Furthermore, the healthcare system in the Tigray Region has been directly targeted by violence, leaving it close to collapse. According to assessments by Médecins Sans Frontières in 2021, around 73% of health facilities have been looted, 30% have been damaged, and only about 13% were still functioning normally. Many centers have been deliberately vandalized or occupied by armed forces. Roughly one in five facilities has been occupied by soldiers, sometimes as military bases, which makes them inaccessible to civilians. The destruction of infrastructure, combined with the loss of staff and ambulances and a lack of supplies, has drastically reduced access to care. As a result, preventable deaths have increased, maternal and child health services have broken down, and patients with chronic conditions or who are victims of violence are often left without care (Medecins Sans Frontières, 2021). As one interviewee who worked in the region described, communities in disconnected villages were entirely reliant on their own two feet to access any form of care. In combination with border disputes and shifting frontlines, this made mobile outreach not just helpful, but the only viable option.

These systemic failures were further aggravated by deliberate acts that directly hindered healthcare delivery, including the blocking of international humanitarian aid, the widespread use of sexual violence as a weapon of war, and credible reports of ethnic atrocities throughout the region (Gesesew et al., 2021, p. 6). The conflict has been heavily criticized by WHO Director Dr. Tedros Adhanom Ghebreyesus, who is from Tigray himself: “This is a health crisis for six million people, and the world is not paying enough attention” (UN News, 2022).

Results/Findings

This section is based on four semi-structured interviews with individuals involved in different emergency responses and approaches within Ethiopia, ranging from before, during and after the Tigray conflict. Anonymity is maintained according to participants’ preferences.

One interviewee from Tigray told us that the war still has a long-lasting impact on the local

population. Displacement, rape and sufferance caused serious trauma resulting in hopelessness, violence, unsafe sexual behaviour and substance abuse among the youth (Assefa et al., 2024). Furthermore, it was mentioned that "they (the TPLF) will always have soldiers" as a consequence of high youth unemployment.

To respond to this mental health demand, the NGO *HAQI* implemented a telephone helpline providing professional psychological first aid. This service is provided for free and in a confidential and anonymous manner, yet it does not seem to have been used by many. This could be because of it being a new concept to their culture, physical needs being prioritized, and also due to technical issues such as telecommunication interruptions. The model is promising and scalable, but it requires sustained financing that the current aid environment, following USAID withdrawal, does not provide. Other post-war interventions are faith-based interventions, Christianity being Tigray's predominant religion, substance abuse rehabilitation and school-based interventions.

However, as mentioned above, the Tigrayan health system has been severely damaged and finds itself unable to recover. Currently, federal fuel restrictions have shuttered gas stations across the region, forcing ambulances off the road, while a thriving black market sells fuel at nearly double the price available in Addis Ababa. Banks have run critically low on cash, leaving civil servants and ordinary citizens unable to access their own funds. Health centres lack essential medicines, malaria and tuberculosis are resurging, and maternal mortality has become alarmingly routine, with women dying in childbirth because ambulances cannot reach hospitals. Schools remain closed or repurposed as IDP camps, teachers are owed up to sixteen months of unpaid salary, and nearly one million people remain internally displaced (Leyti, 2026). Since the war broke out, Tigray has no longer been represented in Ethiopia's parliament or in the federal government (Demissie, 2026).

Health System Strengthening

In Ethiopia, emergency response has consistently been prioritised over preparedness (Oyugi et al., 2025, p. 17). But recently, there has been a shift from relying on external help in case of emergencies in peripheral regions towards ownership in Ethiopia with the establishment of the National Disaster Medical Assistance Team (DMAT) Initiative in 2018, later renamed into the national Emergency Medical Team (N-EMT).

NGOs increasingly pay attention to their exit strategies, preparing and training local actors and reinforcing their capacities to sustain their own response in case of disease outbreaks or emergencies. Our interviewees agreed that HSS in FCAS is challenging and that ownership and involvement of the local people is necessary to build a resilient and sustainable health system.

Such acts of national ownership can be seen in the EMT Initiative. As our interviewee said: "Ethiopia has been at the forefront of every NGO report for the last 20-30 years, but unfortunately, we have had to rely on external support the whole time". *Our generation has to do something.* Their approach now is to train sub-national, multidisciplinary and linguistically diverse teams who are based locally to avoid the time-intensive deployment from Addis Ababa.

Yet, this type of Health System Strengthening never reached Tigray, due to the constant need for emergency response and urgency. Federal institutional support does not extend to a region the government does not politically recognise. What appears at the federal level as a model of national ownership is, from Tigray's perspective, another form of exclusion.

Social Impact

Government-led teams benefit from visible state backing, which can build trust, but in conflict settings like Tigray, this association may also create suspicion and limit access. Interdisciplinarity, multilingualism and religious connoisseurs in the teams have been highlighted as crucial. Humanitarian organisations' neutrality, established through negotiations with all armed parties, provide an alternative form of legitimacy based on impartiality rather than state authority. Generally speaking there were no problems with the population itself, NGOs experienced a high community acceptance and good cooperation amongst technicians. But our interviewees agreed on it being difficult to be apolitical in a political conflict. Some experienced being called a traitor and being a supporter of a certain party although they were just acting in the sole interest of providing healthcare.

To conclude, all of our interviewees were hesitant on whether peace can be achieved solely through health, but agreeing that it is a tool that contributes to it. They don't see themselves as peacekeepers between the parties but as humanitarians following the acute needs.

Discussion

The Ethiopia case ultimately demonstrates the outer limits of what health interventions can achieve when fragility is not merely structural but actively maintained.

The most troubling finding of this case is not the collapse of the health system during active conflict, which is tragically predictable, but rather, its continued and deliberate erosion during the post-agreement period. Rather than serving as a bridge to peace, health has functioned as an instrument of warfare. Fuel restrictions, withheld medicine deliveries and banking restrictions are not administrative failures but calculated acts weaponizing the health system against the population it is supposed to serve. They expose the fundamental fragility of any resilience built on top of unresolved political conflict.

A long-term political horizon is necessary for a meaningful local ownership and, consequently, for a resilient health system in Tigray. Local ownership requires the capacity to plan, finance, and sustain, none of which is possible when salaries go unpaid for months, medicines do not arrive, and the region has had no parliamentary representation for years. The deeply rooted ethnic and political tensions that preceded the war were not resolved by the Pretoria agreement. Instead, these tensions have found new expression in the slow strangulation of public services. Until these tensions are addressed politically, health interventions, no matter how well designed, will only be temporary solutions to an ongoing problem. Without health system resilience, sociopolitical stability in Tigray is not merely distant but structurally impossible.

Pediatric patients in the VHW clinic / epijournal.com

BURUNDI

LONG-TERM COMMUNITY-BASED RESPONSE

Historical Context

Burundi ranks 24th out of 179 countries on the Fragile States Index, reflecting high political instability and institutional fragility (Fund for Peace, 2024). Since independence in 1962, Burundi has experienced repeated instability, including seven coups and six civil wars (Nkurunziza, 2018, p. 4). Rather than stemming from deep-rooted ethnic division, this fragility is linked to Belgian colonial divide-and-rule policies that institutionalized exclusion (p. 8). Between 1928 and 1934, colonial reforms marginalized Hutu participation in governance; Hutu representation among chiefs fell from 20% in 1929 to 0% by 1945 (p. 9). These grievances were later exploited by post-independence elites competing for state resources and foreign aid through repression and violence.

This instability has had severe economic consequences. Political elites are driven by competition for control of the state and its associated 'rents to sovereignty', such as foreign aid, tax revenue, and public investment (p. 22). Cycles of conflict have undermined investment and destroyed infrastructure, leaving Burundi among the world's poorest countries, with approximately 75% of the population living below the poverty line in 2013 (p. 24). The economy remains highly dependent on foreign aid, which averaged 19% of Gross National Income between 1970 and 2014, but is frequently disrupted during political crises (p. 29).

Although the 2000 Arusha Peace Agreement established a framework for reconciliation, its partial implementation and persistent impunity for state crimes continue to fuel grievances, perpetuating cycles of fragility (pp. 5, 16)

The State of Health

Burundi faces a severe and overlapping public health crisis shaped by disease, malnutrition, and environmental shocks (WHO, 2024, pp. 6-11). Endemic diseases such as malaria and emerging threats like Mpox are compounded by a prolonged cholera outbreak since 2023, driven by inadequate sanitation and limited access to safe water (p. 8).

Underlying these challenges is a critical nutrition crisis. Burundi has the world's highest child stunting rate, affecting 53% of children under five, while approximately 18% of the population faces acute food insecurity (p. 1). Rural households are particularly vulnerable, with only 20% of children receiving a minimally acceptable diet (pp. 4, 9). Environmental shocks, including floods and landslides affecting more than 298,000 people since 2023, have further damaged infrastructure, water systems, and agricultural production (p. 3). As a result, access to basic hygiene services remains extremely low (6.3%), while safe water access is limited (62.4%) (p. 11).

Despite relatively high geographic access to healthcare, with over 80% of the population living within 5 km of a facility, service quality is undermined by systemic shortages. Essential medicines are available less than 40% of the time, and Burundi has only 0.6 doctors per 10,000 people (pp. 12-13). Financial barriers further restrict access, as out-of-pocket spending (OOP) accounts for 25.4% of health expenditures and only 22% of the population has medical insurance.

Village Health Works

Village Health Works, founded by Deogratias '*Deo'* Niyizonkiza, is a community-based health and development intervention in Burundi. Its mission combines quality healthcare with efforts to address the root causes of illness, including poverty and inequality. Operating from Kigutu in Rumonge Province (Fig. 1), VHW uses a holistic model integrating healthcare, education, nutrition, food security, and community engagement. Its facilities include Kigutu Hospital and a Women's Health Pavilion, serving patients locally and regionally. The intervention relies on more than 200 Community Health Workers (CHWs), who extend care to remote areas through household outreach, in-home support, and health education.

Figure 1. Village Health Works: About Page. Village Health Works (2026).

Results/Findings

This study uses three semi-structured interviews with individuals linked to the VHW intervention, with anonymity adjusted to participant preference, along with organizational reports and secondary data. The findings highlight interactions between health system resilience, sociopolitical dynamics, and peacebuilding, as well as both strengths and structural vulnerabilities of the intervention.

Health System Resilience: Access, Workforce, and Financing

VHW's resilience is rooted in a holistic service delivery model that prioritizes access and quality. High clinical standards foster sustained community trust, reflected in patient consultations increasing fivefold from 10,000 in 2008 to 50,000 in 2019, and remaining stable at around 52,000 consultations in 2023 (Village Health Works, 2021; 2023). Access is further supported through infrastructure development, ambulance services, and extensive CHW outreach, with up to 80,000 household visits annually.

The workforce model is central to resilience. CHWs act as trusted frontliners embedded within communities, equipped with mobile phones, medical supplies, and logistical support. This system extends service delivery while strengthening local capacity. Efforts to standardize CHW roles with national frameworks also suggest movement toward long-term institutional sustainability. One interviewee further highlighted knowledge and supply sharing with nearby state health facilities, indicating contributions to broader system strengthening beyond VHW's immediate catchment area.

However, financing remains a major vulnerability. Although VHW operates a tiered system combining subsidized care, Carte d'Assistance Maladie (CAM) acceptance, and modest user contributions, interviewees emphasized continued donor dependency. Funding reductions in 2024/2025 led to the

introduction of consultation fees and a temporary decline in service utilization. This reflects broader financial pressures, with operating costs reaching approximately $7.77 million in 2023 while external funding remained essential.

The "Financial Fragility" vs. "Social Resilience" Gap

A key finding is the disconnect between strong social resilience and weak financial resilience. Across interviews, community participation and ownership emerged as defining strengths. The model, described as "by the community, for the community", fostered both physical and social investment, including local contributions to infrastructure such as road construction to improve healthcare access.

This social foundation has produced measurable improvements. Interviewees reported that over 90% of women now choose hospital deliveries, consistent with more than 1,300 safe deliveries recorded in 2023 (Village Health Works, 2023). Infant mortality in the catchment area fell to 25 per 1,000, below the national average of 47 per 1,000, while insecticide-treated bed net usage reached 94% compared to 40% nationally (Village Health Works, 2021).

Despite these gains, the system remains highly vulnerable to external shocks. Funding disruptions, including the withdrawal of US funding in 2024 and cyclical donor transitions, directly affect service continuity and risk reversing programmatic gains. This suggests that externally financed systems in fragile contexts may struggle to sustain the long-term social contracts they help create.

Sociopolitical Stability: Integration, Tension, and Resistance

VHW is deliberately integrated into the national health system to enhance coordination and legitimacy. Rather than functioning as a parallel structure, it works closely with the Ministry of Health and local authorities to align priorities and avoid duplication. This *joint prioritization* strengthens system coherence while maintaining operational effectiveness.

However, the organization operates within a contested political environment. In 2015, NGOs were expelled and labelled *foreign and corrupt*, reflecting broader political instability. Attempts to collect ethnic data on staff and patients further illustrate how health systems can be politicized, undermining neutrality and trust.

Despite this, VHW's long-term engagement strategy, described as a *continuous institutional conversation* with the state, has enabled operational continuity even during periods of instability.

Social Cohesion and Peacebuilding Dynamics

The intervention functions as a neutralizing force in a post-conflict setting, though not in a direct or instrumental way. VHW's "agnostic" approach to care is central to reducing grievances by ensuring non-discriminatory access. This neutrality is reinforced through broader community programs, including agricultural initiatives, youth cultural activities involving over 300 participants in 2023, and Twiyugurure ("Opening Up") sessions focused on trauma and conflict resolution (Village Health Works, 2021; 2023).

However, interviewees were skeptical of framing health as a deliberate peacebuilding tool. Instead, health was viewed as a prerequisite for peace, enabling stability indirectly by restoring dignity, functioning, and social participation. Some respondents also suggested that relative stability may reflect conflict fatigue, with populations less willing to re-engage in violence regardless of improved services. This complicates assumptions about health interventions as direct drivers of peace, highlighting instead their role as enabling conditions within broader sociopolitical processes.

Discussion

Overall, the findings show that VHW achieves high levels of social resilience through community ownership, integrated service delivery, and workforce decentralization, while remaining financially fragile because of donor dependency. This reflects broader understandings of fragility, where instability stems not only from weak institutions but also from unequal access, low trust, and service gaps (McLoughlin & Idris, 2016, p. 6). Literature further suggests that sustainable peace is best advanced through integrated approaches linking health promotion with peacebuilding (Christensen & Edward, 2015, p. 52; Lilja & Ahmad, 2023, p. 2; Ptacek & Connaughton, 2023, pp. 1896-1902).

The case demonstrates that health interventions contribute to sociopolitical stability primarily by strengthening the social contract. Accessible and equitable services act as visible signals of institutional commitment, fostering trust and legitimacy (Witter & Hunter, 2017, p. 2). In VHW, these effects are reinforced through a holistic model extending beyond healthcare to include nutrition, education, and livelihoods, addressing key social determinants of health linked to broader stability outcomes (Aguirre et al., 2022; Saraswathy, 2021).

Importantly, VHW combines healthcare delivery with community-based initiatives that foster interaction and trust across social groups, positioning healthcare spaces and outreach systems as platforms for social engagement. This suggests that while health is not itself a direct peacebuilding tool, it can support conditions for social cohesion when embedded within broader community-oriented development strategies.

However, these gains remain constrained by structural vulnerabilities common in fragile and conflict-affected settings. Dependence on external funding exposes services to financial shocks that can quickly undermine access and trust. This supports critiques that donor-driven interventions may struggle to sustain long-term resilience or legitimacy without stable financing (Zurcher, 2025, pp. 39-42).

The findings also challenge assumptions underlying ‘peace through health’. Rather than directly producing peace, health functions more as a precondition for stability, reducing vulnerability and grievances through equitable, non-discriminatory care (Gordon, 2013, p. 36). At the same time, health systems remain politically embedded, and attempts to politicize care highlight the importance of neutrality for maintaining trust and social cohesion (Rushton & McInnes, 2006, p. 106).

Ultimately, VHW illustrates that health interventions can support stability when they are equitable, community-embedded, and institutionally aligned, enabling states to become more visible and credible in citizens’ everyday lives.

Rob Yates, Chatham House, 2020 / https://www.chathamhouse.org/2020/05/covid-19-era-healthcare-should-be-universal-and-free

SIERRA LEONE

LONG-TERM STATE-BASED RESPONSE

Historical Context

Sierra Leone's contemporary history is one rooted in decolonisation and shifting rule. In 1961 Sierra Leone gained independence from the United Kingdom. The initial years of independence were relatively stable with Sierra Leone's resource rich ground providing fertile means for economic growth. However, corruption and authoritarian dispositions began to seep in, and throughout the 1960s and 70s multiple coups occurred.

In 1991 Liberia's war pushed beyond its borders and Momoh of the All People's Congress party (APC), then President of Sierra Leone, deployed the national military to engage with the National Patriotic Front of Liberia (NPFL). Furthermore, a former army corporal, Foday Sankoh, and his Revolutionary United Front (RUF), began a campaign against President Momoh.

In 1996 Ahmad Tejan Kabbah of the Sierra Leone People's Party (SLPP) was elected president and signed a peace accord with the RUF. However, the peace deal unraveled and a military coup deposed President Kabbah.

A ceasefire in 1999 was called and the Lomé Peace Agreement was signed. However in May 2000 tensions erupted again in Freetown between the Sierra Leonean army and the RUF. In January 2002 the war was declared over and Kabbah won a landslide victory with the SLPP securing a majority in parliament.

However, after 11 years of civil war the country was decimated and its infrastructure crippled. Poverty rates were high and the health system was practically non-functional, with it suffering from a lack of skilled professionals after more than a decade of brain-drain migration.

The State of Health

Following the civil war rates of maternal and child mortality rates still remained exceedingly high. In 2000, Sierra Leone had one of the world's worst maternal mortality ratios (MMR). The number of recorded deaths ranged on average from 1,603 (World Bank, 2026a) to 2,000 (WHO, 2004) per 100,000 live births. Infant mortality (under 5) likewise was high at approximately 223 (World Bank, 2026b) to 225 (WHO, 2024) deaths per 1,000 live births. Furthermore, the density of healthcare workers was extremely low with physicians representing between only 0.3 (WHO, 2026) to less than 0.1 per 10,000 people in 2004 (Witter et al., 2016).

In 2010 President Koroma (APC) introduced the Free Health Care Initiative (FHCI). The goal of the initiative was to provide free healthcare by removing user fees for children under 5, and pregnant and lactating women, in the hopes of reducing maternal and child mortality. An additional aim was to reduce the strain on households from OOP expenditure on health which represented the majority of funding of the health system at the time, approximately 71.6% in 2008 (World Bank, 2026c).

The program focused on seven core policy pillars:

1) Continuous availability of drugs and essential medicines
2) Adequate number of qualified health workers
3) Strengthened governance
4) Development of adequate infrastructure to deliver services

5) Improved information, education and communication to stimulate demand for free high-quality health services
6) A comprehensive Monitoring and Evaluation system
7) Health financing

Thus the FHCI was not just a "vertical programme" focused solely on finance, but sought to address a wide range of problem areas within the health sector and bring about larger system reform (Witter et al., 2018, p. 447).

Results/Findings

A key limitation to this case study was the lack of interviews conducted. Therefore all analysis was done by assessing literature and available data. As previously mentioned, metrics were assessed based on available data, which may not be reflective of accurate realities.

Health System Strengthening

Initially the FHCI saw gains in strengthening of the health system "notably in terms of revitalising structures for sector governance, increased staffing, better systems for staff management and pay, and for getting funds to the facilities. New monitoring and evaluation systems were introduced... and a communication campaign initiated" (Witter et al., 2018, p. 438). This was in part due to the uptake in health financing resources and a switch from household to donor spending to some degree, with aid donors covering more than half the budget of the FHCI in the first year with further pledges for monetary aid to flow for the first few years (Thompson, 2010). However, whilst certain gains were made, "improvements to pharmaceutical procurement and distribution were not effective" (Witter et al., 2018, p. 439).

Yet, health outcomes were generally positive. MMR reduced by over 70% from 2000 to 2023, where available data reported only 354 deaths per 100,000 live births (World Bank, 2026a). By global standards this rate still remains poor, however it marks a drastic reduction domestically. Yet, Witter et al. (2018) suggest that this change cannot be necessarily attributed to the FHCI. Likewise, child mortality under 5 reduced by over 60% from approximately 223 (2000) to 91 deaths per 1,000 live births (2024) (World Bank, 2026b). While prior to the establishment of the FHCI both MMR and child mortality rates were declining, the initiative responded to a clear social need and specifically targeted vulnerable groups in its inception and implementation. Additional aspects previously utilised such as antenatal care saw an uptake in their use and improvement in their quality. Rates of protection from malaria during pregnancy, coverage of postnatal care (increasing by up to 50% between 2010-2014 in cases) and child immunization (up to 68% in 2013 from 41% in 2009) also improved (Witter et al., 2018).

According to Witter et al. (2018), there were "investments in improving infrastructure and referral systems, such as ambulances, and transport under the FHCI, but distance and transport costs remain significant barriers, especially for remote communities" (p. 442). Improvements to the health system workforce made up 50% of the direct FHCI costs, and 25% of the broader increases in health expenditure (p. 444).

Discussion

According to Witter et al. (2018), "in countries with weak health system[s], a reform-like fee removal, if tackled in a systematic way, can bring about important health system gains (p.1), as well as "act as a catalyst for broader health system reforms" (Witter et al. 2016, p. 2).

State Legitimacy & Social Cohesion

The FHCI was a success in several aspects of its implementation within the health system. In terms of its relation to political legitimacy and social cohesion, M'Cleod & Ganson (2018) argued that improvements to state legitimacy are non-existent and that in Sierra Leone the State is "only tolerated as long as its impacts were not excessively negative" (p. 17). They cite the 2014-2016 Ebola outbreak to showcase "the lack of trust in state officials, weaknesses in the healthcare system and the system of governance in general" (p. 24). However, mechanisms of the FHCI explicitly sought to address issues of corruption, transparency and accountability within the national health sector. This was achieved through a series of visible reforms, including the removal of ghost workers from the payroll under the monitoring of the Payroll Steering Committee (PSC), substantial salary increases ranging from at least 90% to over 700%, and accelerated recruitment processes (Stevenson et al., 2012; Yates, 2010; Witter et al., 2016). Salary increases were introduced partly to reduce the reliance of healthcare workers on informal user fees to supplement low incomes (Stevenson et al., 2012). Although OOP expenditure had officially declined by nearly 20% by 2023, these figures may not fully reflect patients' actual experiences and payment expectations (World Bank, 2026c). Human Rights Watch (2025), in examining the effectiveness of government efforts to remove financial barriers to maternal healthcare, found that informal fees and forms of obstetric violence persisted, highlighting the continued complexity of implementing the FHCI.

The embedment within the national health system of this change played a critical role in the strengthening of HSR. According to Stevenson et al. (2012), "embedding the salary uplift and the engagement of all senior level stakeholders via their membership of the [PSC] has helped to foster ownership and commitment. It also provides a useful mechanism for strengthening [Government of Sierra Leone's] capacity for performance management and cross-Ministry collaboration" (p. 4). A key area where systemic change is needed is the health workforce, as in post-conflict settings it is often deeply disrupted yet often overlooked in rebuilding attempts (Witter et al. 2016, p. 2). As of 2024 the rate of doctors, nurses and midwives now sits at approximately 6.4 per 10,000 population, however this augmentation may not provide accurate data on improved access to care due to the increase of *surplus* health workers (unsalaried volunteers) since 2010 (Pieterse & Saracini, 2025, p. 1).

Just two weeks prior to the official launching of the FHCI, there were major nation-wide strikes of healthcare workers. The political will of the government and President Koroma, was a key factor in the success of FHCI. This was evident with the President putting "the healthcare directive at the top of his priority list. Political will drove the process" (Donnelly, 2011, p. 1393). The government highlighted this will, and

built up trust in their donors and the public by addressing the strike, “pledg[ing] its own funds to pay for increases in salaries. That was not lost on donors, and it later triggered more donor funds for the FHCI” (p. 1394).

The involvement of the community and civil society within the monitoring and evaluational aspect of the FHCI may also be considered a potentially notable improvement in addressing prior social distrust of government institutions (Stevenson et al., 2012). However, this trust is not concrete. The mismanagement of the Ebola outbreak highlighted how weak the health system remained, as well as highlighted the need for continual political motivation and engagement with the community.

Overall in terms of stability Sierra Leone has generally improved since 2006, where it was ranked just 16th least stable globally (out of 179 countries). Currently it is 45th (2024) (Fund for Peace, 2024). Whether any of this gain in stability can be attributed to the FHCI is up to interpretation.

Common Themes

The evidence presented from Guinea, Ethiopia, Burundi and Sierra Leone highlight the impact of health on strengthening state legitimacy and state-society relations. This study has highlighted the complex nature of health, its system and its influence on broader societal trends. While these countries differ in region, history and current political tensions, all have experienced immense fragility and attempts to address health concerns either during conflict or amidst post-conflict rebuilding stages. This report has offered insights into the context-based approach followed by four different health interventions, and evaluated their success. This is by no means a guidebook on how to effectively utilise health initiatives to bring about peace. However, it does note the overlap of consistent elements of each which reflect positive aspects that may be utilised in future programmes.

1. Political Will

Political will amongst government, donors and the public for the general prioritisation of health is a driving factor in the effectiveness of health initiatives in FCAS. Through our study, we have identified three key areas where political will can manifest to produce tangible results; these areas are reflected in the following recommendations.

Recommendations:

Health promotion campaigns

When communicating to target audiences it is important to facilitate their empowerment in decision making. This is primarily operationalised by making health messages simple and clear. Health promotion should be done in collaboration with community leaders, fostering inclusivity and community trust. In Guinea, health promotion campaigns were done through community and religious leaders consultations, as well as innovative approaches such as local theater performances.

Visible and neutral service delivery

Where health interventions were visible, neutral, and transparent, uptake and community acceptance tended to be stronger. Keeping health framed as a superordinate and politically neutral goal therefore appears essential. At the same time, the findings highlight the importance of adapting interventions to specific local contexts. This dynamic was reflected positively in cases such as Burundi, where health acted as a neutral entry point bringing together previously conflicting groups, and Sierra Leone, where visible government-led improvements to the health system strengthened public trust. Conversely, the Ethiopian case illustrated the consequences of failing to safeguard health as a neutral right. As one NGO worker noted, “as soon as you touch politics in those countries, they will ask you to take the next plane and that's it”. A local professional also highlighted that “some places were not put in 'priority'... because those people were kind of opposition leaders or people of the government. So in that case, unfortunately, they will get something, but they will get it late”.

2. Fragility of Funding

Funding modalities, their implementation, sustainability and thus their adaptation when funding ends, is extremely important and highly

impactful on aid effectiveness. Two key areas where funding should be addressed in an initiative's design.

Recommendations:

Health System Strengthening Earmarked Funds

A portion of health intervention funding should consistently be allocated to health system strengthening and systemic reforms in order to reduce the long-term effects of weak health systems. Sierra Leone provides an example of this approach, with around 50% of the programme budget reportedly dedicated to addressing structural health system challenges alongside immediate response needs.

Exit Strategies

Sole dependence on foreign aid can potentially contribute to fragility of interventions, by undermining the sustainability of financing modalities of a programme. Underfunding, due to limited budgets in FCAS, may lead to a dependence on unsustainable and shock-prone forms of funding. To address this, blended finance structures should be priorities. Looking at diversifying the portfolio of funding streams is important, whether this is between donors or domestically. "[E]armarked taxes and efficiency savings [that are]… planned, and implemented for their introduction in the near term" (Witter et al. 2018, p. 446) can provide an exit plan for when funding ends.

3. Local Ownership

The need for community engagement was a core theme we identified across all four case studies. Local ownership was shown to foster trust in institutions, increased utilisation of services, and improve social cohesion. For any given health initiative community and grassroot elements must be integrated. "By the community. For the community", a motto for VHW, highlights how the community should be at the heart of health.

Recommendations:

Community-led level health system surveillance

In highly decentralised states with diverse ethnic communities, health systems that endure are often those embedded at the community level. Even in more centralised systems where health is governed through the Ministry of Health, key surveillance mechanisms still rely on community-based structures. This is evident in Guinea, where community actors were integrated into existing epidemiological surveillance systems, and in Burundi, where community health workers identified health emergencies and referred cases to Village Health Works VHW facilities. In Sierra Leone, community engagement was also reinforced through patient exit surveys that monitored whether informal charges were being levied, strengthening accountability at the point of service delivery.

Local capacity building & workforce training

The training and retaining of local staff is a key determinant of sustainability across health interventions, although it is more challenging to implement in humanitarian emergencies than in development settings. Capacity development and local workforce training are therefore essential priorities for ensuring the long-term viability of interventions. This is reflected positively in cases such as Guinea, where WHO and IOM

programmes trained and employed local staff, and in Burundi, where most on-the-ground personnel were locally trained. In Sierra Leone, the building up of the workforce mainly occurred through re-incentivization strategies including increased pay and better recruitment processes. In contrast, the Ethiopian case illustrates the limits of this approach in active conflict settings, where NGO operations and WHO WASH training were restricted in Tigray, although local workforce training continued in other regions of the country.

Local capacity building & infrastructure

Local infrastructure, both within and beyond the health sector, is a key factor in strengthening health system performance. These improvements extend beyond direct health facility upgrades to include the auxiliary systems that support effective service delivery. This is evident in Guinea, where investments included solar panels and electronic data systems, and in Burundi, where infrastructure development extended to roads and agricultural projects supporting broader community resilience. In Sierra Leone, while some regional health facilities improved drug procurement systems, even when this remained a persistent challenge at the national level.

Decentralization

The decentralisation of health workforce distribution and infrastructure is advisable, as while responses should remain nationally coordinated, they must also be adapted and localised to specific contexts to ensure effectiveness and impact. This is reflected positively in Burundi, where the intervention was operationally and financially decentralised from the national health system, while still remaining integrated enough to strengthen it over time. In contrast, the Ethiopian case highlights the risks of fragmented or politically constrained access, as illustrated by the statement of a Tigrayan health professional: “The EMT never came. They would not come to Tigray”.

Knowledge Sharing

Interventions should prioritise knowledge sharing across the local medical landscape to strengthen system-wide capacity rather than isolated gains. This approach was particularly evident in Burundi, where actors actively supported the diffusion of skills and resources beyond a single institution. As one interviewee from VHW noted, “when we got some of the testing and diagnostic equipment, we actually asked the government…if we could purchase one or two more and put them in other hospitals…so that they would also receive some of the benefits”. Another worker from VHW highlighted: “we’d invite some of the doctors to come and train at our centers or send some of our doctors to train them. So it was a lot of knowledge sharing”.

4. Coordination

Lastly, across the case studies, particularly in Burundi and Guinea, it became clear that coordination is essential for improving funding efficiency, ensuring consistency in care, and achieving equitable coverage across all populations in the country.

Recommendations:

Defined steward as central coordinating actor

Health interventions should ideally be nationally integrated, with the Ministry of Health acting as

the central coordinating body from the outset. Positioning the Ministry in this role is particularly important for fostering long-term resilience and strengthening local coordination capacity. This is reflected in Burundi, where one interviewee from VHW noted that "each organization working around health thematics must work with the Ministry of Health", as well as in Sierra Leone, where the response was structured as a government-led national initiative. However, in highly fragile contexts, the Ministry of Health may not always be able to function effectively as the lead responder. In such cases, coordination responsibilities should be clearly defined early in the intervention, with agreement among stakeholders on the most appropriate lead actor to ensure coherent response and efficient resource allocation.

Consolidating actors

With multiple actors typically involved in most interventions, effective coordination is essential to ensure alignment around shared objectives. Clear division of labour can improve funding efficiency and reduce duplication of services, as illustrated in Guinea, where different actors provided the same training at different points in time. Strengthened coordination is also critical to minimise competition over funding, geographic coverage, and visibility, which can otherwise undermine coherence and effectiveness of the overall response.

Coordination & Inclusivity

As seen in the cases of Guinea and Burundi, effective coordination across multiple levels of actors, alongside the inclusion of these stakeholders, is fundamental. This includes coordination with national governments, regional political actors, and local communities. Broad-based engagement across all levels of society is necessary to ensure that responses are comprehensive and capable of addressing needs across different sectors.

Multisectoral coordination & addressing social determinants of health

Cross-sectoral collaboration between health interventions and external sectors such as agriculture, infrastructure, and transport is essential, as reflected in the cases of Guinea, Burundi, and Sierra Leone. Addressing social determinants of health should therefore be integrated, at least to some extent, into the design of any health initiative. This includes incorporating measures that reduce structural barriers to access from the outset, such as Sierra Leone's removal of user fees to address socioeconomic constraints, and Burundi's focus on expanding rural services to mitigate geographical barriers.

Conclusion

Through process-tracing, this research combined descriptive quantitative data, secondary sources, and qualitative expert interviews to examine how the design and implementation of health interventions influence HSR, health outcomes, and potential spillover effects on sociopolitical stability in FCAS.

The study faced several limitations, including limited data availability, challenges in identifying and accessing key informants, contradictory sources, and potential professional, political, and personal biases. In Sierra Leone, actors directly involved in the intervention could not be interviewed, while in Ethiopia the case study scope was narrowed due to a limited pool of participants. These gaps were addressed through secondary sources and cross-case comparison.

Existing literature highlights a reciprocal relationship between health systems and sociopolitical stability: reliable service delivery and strengthened health infrastructure can foster public trust, reinforce governance, and reduce grievance-related drivers of fragility, while stable political environments are more conducive to positive health outcomes (Haar & Rubenstein, 2012, p. 289). Factors such as poverty, limited education, and poor access to services are closely linked to violent conflict and weak governance, suggesting that health interventions may generate meaningful second-order effects over time (Zürcher, 2025, p. 50).

The findings indicate that health interventions can contribute to HSR in FCAS, though impacts are uneven and highly context-dependent. Interventions were most effective in post-conflict and transitional settings where system-building opportunities existed, whereas active conflict severely constrained outcomes due to limited capacity, funding uncertainty, and restricted political space. Success was closely tied to enabling conditions such as political context, sustained and predictable financing, localization, and effective coordination. At the same time, heavy dependence on external aid exposed systems to funding shocks, making gains difficult to sustain, replicate, or scale.

Varying degrees of HSR were observed in Guinea, Burundi, and Sierra Leone, contributing indirectly to sociopolitical stability through improved access to services, reduced grievances, and strengthened trust in institutions. In Guinea, the Ebola response enhanced state legitimacy and social cohesion, while in Burundi interventions more directly reinforced the social contract. In contrast, limited progress was observed in Ethiopia. Across cases, observed stability effects remained primarily indirect and contingent upon broader peacebuilding and governance dynamics.

Overall, health-focused aid should be understood as a powerful but limited complementary tool. Under the right conditions, it can support resilience and stability, but it cannot replace broader political solutions. These findings underscore the need to broaden approaches beyond traditional peacebuilding and explore alternative pathways to peace and stability, including health-focused interventions. Finally, there is a clear need for further research on the mechanisms linking health systems and sociopolitical stability.

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Appendix

Table 1: Analysis Indicators

Green: Health System Resilience
Yellow: Sociopolitical Stability
Blue: Peace & Health

Indicator	Description
Service Delivery	Whether the system can provide consistent and equitable services (1) Facility continuity (closures or service interruptions), (2) the extent of community-oriented outreach, (3) proportion of facilities delivering the defined service package. Together these capture legitimacy, resilience, and equity in service areas.
Health Workforce	Overall availability of medical professionals and facility-level readiness for emergencies, specifically, the presence of designated emergency/continuity focal points and access to rapid response teams (surge capacity and operational preparedness).
Health Information System	Health system's ability to detect threats early and sustain cooperative relationships with the population through surveillance and response systems.
Embedment of Health Intervention with the State	Engagement and institutionalization of a health institution within the national or state government infrastructure, planning or financing.
Access to medicines and other health products and technologies	Availability of essential medicines and basic WASH standards at facilities will serve as core measures of service quality and safety, signalling state capacity.
Trust in State Institutions	Citizens' confidence in governing bodies, including the health ministry and related agencies.
Health Financing	Mechanisms that reduce financial barriers; such as user-fee waivers, contingency funds, and other measures supporting affordable access, signalling equity.
Governance	(1) the presence of clear protocols for service prioritization during crises and (2) plans/models for reaching hard-to-reach or marginalized populations. These collectively reflect ethical decision-making,

	transparency, and inclusion.
Perceived State Legitimacy	The extent to which the public believes the government has the right and authority to govern.
Cooperation with Health Programs	The willingness of the population to engage with public health initiatives (e.g., vaccination campaigns, contact tracing), reflecting practical trust in the system.
Social Cohesion and Intergroup Relations	The level of harmony, trust, and cooperation among different societal groups, which can be affected by perceived inequalities in service delivery.
Living Conditions and Perceived Safety	Indicators of the security environment and quality of life, which improve when public services are reliable and health threats are effectively managed.

Table 2: Key Informant Interviews

Identification Number	**Country Case Study**	**Participant Name (if consent provided)**	**Description**	**Date of Interview**	**Modality of Interview**
Participant 1	Guinea	Luca Fontana	WatSan Manager in the Guinea Ebola response, MSF	11/03/26	Online
Participant 2	Guinea	Mory Keita	Coordinator for the strengthening of Integrated Diseases Surveillance and Response (IDSR) in Guinea, WHO	12/03/26	Online
Participant 3	Guinea	Alessandro Cassini	Professor of the Global Health Institute, Université de Genève	13/03/26	In person
Participant 4	Guinea	Isabelle Devaux	Epidemiologist and field coordinator in the Guinea Ebola Response, WHO	17/03/26	Online
Participant 5	Guinea	Alexandre Robert	Border Health Project Officer in Guinea, IOM	1/04/26	In person
Participant 6	Guinea	Facinet Yassara	Former lead of Ebola Surveillance and Community Health in Guinea, National Health Security Agency of Guinea	8/04/26	Online

Participant 7	Guinea	N/A	Professor at the École de santé publique de l'Université de Montréal	16/04/26	Online
Participant 8	Ethiopia	Jean Pierre Veyrenche	Former advisor for WASH, WHO	12/03/26	Online
Participant 9	Ethiopia	N/A	N/A	16/03/26	Online
Participant 10	Ethiopia	Nahom Tadelle	Emergency Medical Team Leader, Ethiopian Public Health Institute	09/04/26	Online
Participant 11	Burundi	N/A	Capacity Building Officer, Village Health Works	20/03/26	Online
Participant 12	Burundi	N/A	N/A	24/03/26	Online
Participant 13	Burundi	Wilfried Irambona	Community Health Programme Coordinator, Village Health Works	27/03/26	Online
Participant 14	Ethiopia	N/A	N/A	27/04/26	Online

Key Interview Questions

Context

- What was your role in the intervention? If you could tell us more about your experience in the intervention?
- What were the core objectives of the intervention?
    - What were the primary drivers for choosing this specific intervention design (short-term or community-based) given the volatile environment?
- In what ways did the program have to pivot or adapt its design in response to shifting local political or conflict dynamics?
- What was the degree of co-operation of the intervention with national or local structures? Was it in conjunction or was it running parallel to them?

Health System Resilience

- Beyond immediate health outcomes, how did this intervention support the ‘absorptive’ capacity of the local health system to maintain services during shocks?
- To what extent did the intervention address the health workforce and infrastructure needs in a way that remains sustainable after the project funding ends?
    - What specific steps did you take to ensure sustainability/better crisis response/the intervention continued?

- Was the health system resilience incorporated into the design programme or was it an added feature later?
- How did the funding modality (bilateral, multilateral, or philanthropic) influence the implementation or prioritization of services on the ground?
- Did the financing mechanisms change throughout the programme to address weak aspects of the intervention?

Sociopolitical Stability

- Did the project reach 'hard-to-reach' or marginalized populations? How did the intervention handle the decision-making involved in prioritizing these groups?
- Did you observe any changes in the population's perception of state legitimacy or trust in government institutions/medical institutions as a result of this health intervention?
- Was there evidence that the health intervention helped mitigate intergroup grievances, or conversely, did it inadvertently create new tensions regarding who had access to care?
- Did the programme help mitigate or conversely worsen mistrust in health institutions?
- In your experience, does visible service delivery actively strengthen the social contact between citizens and state, or is this link often overstated?
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Peace & Health

- Do you believe health interventions can be intentionally designed to foster peace, or are the peacebuilding benefits usually secondary/unintended outcomes?
- How did the program address existing public mistrust of state institutions, particularly if the state was viewed as a party to the conflict?
- If you had to do this all again today, would you do anything differently?

Key Questions (Case Studies)

- Are there any reports or community feedback mechanisms that document this perception? (Burundi)