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Research Paper

Health reform futuring in Sierra Leone: Beyond synergy or fragmentation

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Covid-19 created opportunities for countries to rethink health systems to better address future crises. While a Lancet Commission on synergies between Universal Health Coverage (UHC), Health Security and Health Promotion implicitly framed 'synergy' as desirable and 'fragmentation' as undesirable, this binary obscures the political and post-colonial conditions under which many health agendas are enacted. Drawing on qualitative data collected in Sierra Leone in 2019, this article argues that health reform futuring is politically and ideologically constrained by limits placed on how human health futures are envisioned. In Sierra Leone, practices labelled as deleteriously fragmentated can, in fact, reflect forms of local agency and resistance against donor-driven, neoliberal interventions. Reframing fragmentation through a decolonising and sovereignty lens can help explain why repeated crises, including war, Ebola, and Covid-19 have failed to make better use of crisis to bring about anticipated health systems changes in Sierra Leone. Problematizing synergy and fragmentation highlights the urgent need to re-centre context-specific priorities and to interrogate the global structural conditions and impositions that discourage universal health care futures as a first priority. Ultimately, we underscore the need to make health reform futures possible through both synergies and fragmentations, directed by local leadership.

Introduction

In the immediate wake of the Covid-19 pandemic, global health discourses were dominated by calls to 'build back better' (OECD 2020) and address the ills of the past in ways that would pre-empt them from occurring in the future. Five years later, in early 2025, the closing of the US Agency for International Development (USAID) and the subsequent drawdowns of health aid have, in many countries, made reform imperative in the face of what many people in international affairs (e.g., Coughlan & Mehta 2025) describe as anticipatory spaces that are 'urgent' and 'anxious' (Adams et al. 2009).

Over the last 50 years, international health sector reform projects have used post-crises moments to imagine improved health futures (Kingdon 1995, Kolie et al. 2019, Birn 2020). These projects often assume futures that *can* be managed and human harms averted *if only* systems are properly aligned and

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reconfigured with global systems. More recently, future-oriented logics have driven efforts to bring local health systems in line with global frameworks. We use one such international reform project – the Lancet Commission on Synergies (Agyepong et al. 2023) – as a site to explore the opportunities and constraints of such reform futuring. The Commission's work, of which author M'Cormack-Hale was a part, juxtaposed 'synergy' and 'fragmentation', as narrative frames. Synergy was heralded as a desirable alignment of interventions that would enable the advancement of multiple health agendas simultaneously; fragmentation was deemed undesirable and a major impediment to effective health governance (Ooms et al. 2018, p. 1098).

The Commission aimed to 'synergize' Universal Health Coverage (UHC), Health Security, and Health Promotion. While analytically compelling, this framing implicitly treated reform that prioritized coordination as both technically and politically desirable, and fragmentation as evidence of failure. Our article raises questions about this juxtaposition, elaborating on unheralded benefits of fragmentation as diversification, a strategy central to survival in pre-colonial West Africa (Franke & Chasin 1980). The synergy-fragmentation binary is insufficient for understanding the dynamics of health reform futuring. The Commission recognized that what is often labelled fragmentation reflects not simply the challenges of coordination but also deeper structural inequalities, external donor power and priorities, and context-specific adaptations. However, rather than viewing fragmentation solely as a governance problem to be corrected, closer examination reveals tensions between globally imagined health futures and locally lived presents that can be productive. Expressly, we do not advocate for complete fragmentation of health service delivery. Rather, we use a 'coordinated-enough' measure when health delivery serves a community or nation via a beneficial diversification of health praxes and effects that improves health outcomes. As the lessons of over-reliance on US aid and global philanthropy have clarified since early 2025, diversification can be life-saving. This article updates Agyepong et al. (2023), which was written before that 2025 decimation of global health aid.

Reform is not a neutral or purely technical project, and we invoke Roitman's qualification of crisis 'as a device for understanding how to act effectively' (2017, p. 23). But we also note that crises can prevent people from engaging in critical reflection (Redfield 2013), resulting in interventions that may ignore local political realities and other complexities. Such has been the case with decades of noblist calls for synergy over fragmentation in global health.

Rather than strict alignment with international ideals, we argue that fragmentation as diversification can provide social spaces where sovereign decision-making can emerge in the face of competing priorities between global and national actors. As we can see in the case of ongoing health reform in the west African nation of Sierra Leone, which we feature in this article, anticipatory futuring does not merely require anticipating potential health crises; it actively reorganises political attention and priority-making in the present. By recentring Sierra Leoneans as the actors who, ultimately, possess the most to gain and to lose with in-country health reform, we draw too on Prainsack's (2022) 'sociology of expectations.' In conjunction with reform as an opportunity to imagine desirable futures, she writes of expectations as potentially productive, emancipatory even, leading to tangible positive changes (Prainsack 2022). Actual change calls for actions that *counter* the fundamental ways our worlds are structured, requiring a reimagining of social spaces that emerge only when local contexts and local voices/actors come forth. Further, Prainsack (2022) explains why top-down calls fail to alter the local status quo: complexity. Engaging with actual complexities starts with looking at what people in their communities do to change their circumstances and realities. Calls for synergy that ignore complexity prove too facile. Simply calling for synergy without engaging with complexity can doom us to repeat the same problems over and over again. Instead, Prainsack encourages us to 'harness complexity,' to work to understand the structural underpinnings of the issues we aim to reform. Failing to recognize complexity in articulating a desired future dooms reform efforts to failure.

Historically, health reforms brought by the international community for Sierra Leone have required what Benton (2015) called 'disease exceptionalism', wherein the global elevation of some disease outbreaks as urgent security threats focuses local policy attentions and limited resource allocation around

one disease, excluding other critical local concerns. Sierra Leone, for example, was flooded with international aid funding and health resources for a disease, HIV, that, although devastating to the individuals who contracted it, was not as significant a population health threat as malaria, tuberculosis, and, more recently, diabetes. Framing HIV as an urgent, stand-alone emergency ignored how emergency containment measures – which were synced to global health priorities – interacted with a neglected health system, food insecurity, informal economies, and weak state capacity, which exacerbated overall population health vulnerabilities rather than reducing them (McLean & Malcolm 2023). Broadly speaking, this led to governance landscapes forced to rank present and future disease risks, not always in terms of real threats to local populations, but in terms of imagined future threats to a health imaginary of global proportions (Lees et al. 2022). Determining which health risks matter when, whose vulnerabilities count the most, and which interventions appear most legitimate show us which *structures* and whose *approaches* matter the most in the global political economy of health.

Health reform and the crises that often catalyse it, as we aim to show, are multiplicities of past, present, and future. 'The future is inhabited in the present' (Adams et. al. 2009, p. 249); actions undertaken to address potential crises in the future have implications on how lives are lived and what is prioritised in the present. In Sierra Leone during the 2014-2016 Ebola outbreak, framing health crisis as episodic rather than endemic had deep and widespread societal implications. Lipton (2024) argues, correctly in our view, that the outbreak in Sierra Leone should not have been understood simply as an exceptional health emergency. That characterization drew attention away from the long-standing structural needs for building a functioning primary health system. Despite repeated calls to improve health care provision, fundamental health system transformation remains elusive. This persistence raises critical questions about why crises that are widely described as opportunities for reform so often reproduce continuing fragility.

Understanding reform as a kind of futuring, therefore, requires engaging with multiple complexities rather than suppressing them, and rethinking whose visions shape the futures of health reform. We follow Lees et al. (2022), who make a case for deeper contextual understandings of crisis framings, a need which has become increasingly poignantly urgent with the reduction of global health aid since 2025 that has forced revisionings of health futures throughout the world.

Methodology

To further elaborate on our notion of *health reform futuring*, we use the Lancet Commission on synergies process (Ooms et al. 2018) as a springboard for analysis of futuring in global health before 2025, when US-led global health aid operated as an industry with recognizable norms and customary practices. That was a time when the demands and expectations placed on countries like Sierra Leone by internationally-driven recommendations and reform efforts carried weight that typically exceeded that of local experts.

Convened in 2018 just before the Covid-19 outbreak, the Lancet Commission on synergies sought to understand the drivers of synergy and fragmentation in advancing three health agendas. Borrowing from the Commission's working definitions, UHC is conceptualized as the most critical activities for access for all to quality essential health-services, including medicines, vaccines, and financial risk protection linked to payment for services. Health security was considered the most important element for reducing human vulnerability to rapidly spreading risks to health, particularly those with great potential to cross international borders. Health promotion refers to key activities that enable people to increase control over the determinants of their health and change social, environmental and economic conditions to improve health. The Commission defined synergy as an intervention, institutional capacity, or policy that positively advances two or more of these agendas simultaneously. Fragmentation, by contrast, is described as the proliferation of uncoordinated initiatives, vertical programmes, and institutional duplication that undermine system-wide coherence (Agyepong et al. 2023).

This study draws on qualitative research conducted by author M'Cormack-Hale between July and December 2019 as part of the Sierra Leone case study for the Commission. Data collection used

predominantly qualitative methods, combining key informant interviews with an extensive desk review of policy and programme documentation. Interlocutors were identified using a snowball sampling approach drawing from M'Cormack-Hale's pre-existing work in the healthcare sector and knowledge of key stakeholders in Sierra Leone's Ministry of Health and Sanitation. An initial set of interlocutors was generated from a list of key people within the ministry at the district level, who then identified other potential participants. In total, 18 semi-structured interviews were conducted with governmental interlocutors at national and district levels, including ministry officials, district medical officers, medical superintendents, councillors, and senior nursing staff. In addition, two interviews were conducted with representatives of donor and non-governmental organisations active in the health sector. To preserve anonymity, interlocutors are described only as 'governmental' (national and district level interlocutors), and 'non-governmental' interlocutors (donors). All participants provided written informed consent prior to participation, and ethical approval was obtained from the Ghana Health Service Ethics Review Committee (GHS-ERC 007/03/19), as the Sierra Leone research formed part of a two-country study spearheaded by Ghana.

Interviews were transcribed by the three research assistants who collected the data. Author M'Cormack-Hale conducted data analysis, along with two additional research assistants. This entailed reviewing the transcripts for themes and sub-themes and coding based on the research questions, using inductive and deductive approaches (Bowling 2009, Bryant & Charmaz 2007). Emergent themes from the interview data were discussed and agreed upon by author M'Cormack-Hale and research assistants to ensure quality assurance and data triangulation.

A desk review of relevant grey literature was conducted by author M'Cormack-Hale and research assistants. It included Sierra Leone national health policy and strategy documents, service level agreements housed within the Integrated Health Planning and Administration Unit, donor programme documents, Ebola recovery plans, and routine health management information system data. These materials were essential for tracing how global frameworks and donor financing intersected with national health priorities, particularly given the absence of financial data disaggregated along the three health agendas of universal healthcare, health security, and health promotion.

Rather than treating synergy and fragmentation as objective technical variables, our analysis focuses on how interlocutors invoke these concepts and what this revealed about power relations, institutional constraints, and perceived agency within Sierra Leone's health system. This approach aligns with our broader analytical aim: to understand synergy and fragmentation as political and discursive categories embedded within a post-colonial and donor-dependent health architecture. Author Erikson, who has extensive research and healthcare service delivery experience in Sierra Leone, contributed conceptual and written article aspects.

The article continues in six parts. Next, we briefly set out how we have woven together the Commission's framework and Prainsack's (2022) notion of imaginative captivity to introduce how failures of imagination can be self-limiting to health reform futuring. Then we give a brief history of the political economy of health in Sierra Leone to set the stage for a fulsome presentation in the following section about how interlocutors experienced the push and pull of synergy and fragmentation before, during, and after both the 2014-2016 Ebola outbreak and Covid-19 pandemic. This is followed by two sections: first, on the problems of pushes for synergy in Sierra Leone, and then on what we're calling 'managed fragmentation' or diversification as a form of resilience. In our concluding sections, we further theorize the future of health reform in a world that is fragmented by the design of the global political economy of health.

Theoretical Frames: Synergy, Fragmentation, and Imaginative Captivity

In the Commission's conceptual framework, synergy became associated with a desirable vision of the future, one in which health systems are integrated, resilient, and aligned with universal standards.

Fragmentation was cast as undesirable, a failure to align and coordinate, a residue of the past that must be overcome. The implicit assumption was that greater synergy would improve health care outcomes (Agyepong et al. 2023, Agyepong et al. 2021, Ooms et al. 2018, Rudasingwa et al. 2022, Sarker et al. 2022) and that fragmentation was dysfunctional. However, scholars in critical global health, postcolonial studies, and medical anthropology have highlighted the limitations of that assumption, and we contribute to that position here. Benton's (2015) work on HIV/AIDS exceptionalism and Hirsch's (2024) analysis of antiblackness in global health both show how global health governance not only consistently privileges Northern expertise and Northern concerns but also operates on underlying racist logics.

In this article, we treat fragmentation not as a holy grail, but rather as a governance condition that functions as both a constraint and a pragmatic strategy. By conceptualising fragmentation as a potentially productive, if imperfect, feature of health governance, this article moves beyond conventional health preparedness prescriptions toward a more grounded understanding of how health systems function in practice. The Sierra Leone case illustrates that fragmentation can create spaces for learning, experimentation, and locally informed decision-making, even as it coexists with enduring, often donor-imposed structural challenges. Recognising these multiplicities is essential for understanding extant pressures on health care reform and for identifying pathways toward more resilient and context-sensitive futures.

We situate the synergy-fragmentation debate alongside Prainsack's (2022) concept of imaginative captivity, a condition in which societies become captive to entrenched practices, institutions, and ideologies that narrow the range of futures that can be imagined and enacted. In global health, problem solving is often constrained by funding modalities (Erikson 2025), aid metrics (Erikson 2012), and crisis narratives that privilege anticipation of future threats over sustained investment in present needs and capacities. Prainsack (2022) offers insights into both the constraints that repeatedly undermine health reforms and the spaces of agency through which Sierra Leonean policy and program governors negotiate alternatives. As we show, future-oriented interventions can entrench the very conditions that too often make transformative futures unattainable. Our analysis not only illustrates the limitations of anticipation as a temporal politics (Adams et al. 2009) which cannot escape storied pasts, but also shows how imagined futures can be held back by the inability to properly account for the complexities of the present.

A Historicized Political Economy of Health in Sierra Leone

British colonial rule of Sierra Leone – the assertion of rule began in 1787, was formalized in 1808, and ran until Sierra Leone's independence in 1961 – left deep deficits in colonial state healthcare (Bolt & Cilliers 2025). Colonial medical infrastructure in Sierra Leone was designed primarily to protect European administrators rather than the local population (Cole 2015), with locals largely seen as disease vectors (Frenkel & Western 1988). Rural communities also found it difficult to access health facilities which tended to be located primarily near administrative city and town centres (Logan 1985). These exclusions shaped post-independence health infrastructure and contributed to persistent inequalities in access to and quality of care, which was compounded by the 1970s and 1980s neoliberal turn orchestrated by international financial institutions (IFI), primarily the World Bank and the IMF (Erikson 2025, pp. 47-59). The resulting economic instability fuelled coups and political upheaval, conflicts that intensified and brought the country to war from 1991-2002, during which about 75 percent of the country's health care facilities were destroyed or vandalized.

Neoliberal reforms initiated in the 1970s and 1980s by multilateral development banks grossly limited spending on healthcare and public health. As Liberian scholar Robtel Pailey (2014) argues, while countries 'have been urged in the past to prioritise conventional macro-economic policies of liberalisation, privatisation and deregulation, they have not been similarly supported to build strong public health systems as a development imperative.'

Like many other countries in the global South, Sierra Leone aligned with several international commitments on health as a matter of survival. The country is a signatory to a host of international declarations and policies, and there has been a sustained desire on the part of the government, regardless of the party in power, to enlist international aid. At the national level, synergy has been most visible in areas where alignment with international frameworks was required or incentivised by donor expectations. Donor hesitance to channel funds through public government systems has entrenched hybrid arrangements in which state and non-state actors unevenly deliver health services. Even before the Ebola outbreak, health sector interventions in the immediate aftermath of the civil war were primarily confined to rebuilding clinics and hospitals, prioritized over investments in staffing. Moreover, international investments in the region have historically favoured vertical funding of diseases of interest to donors, such as HIV/AIDS, malaria, and tuberculosis (EURODAD & Campaign for Good Governance 2008, Wright et al. 2015).

As Denney et al. (2015, p. 9) highlight, this approach yields a fragmented, project-driven aid and ad hoc health service delivery landscape rather than a cohesive health *system*. Yes, the healthcare system in Sierra Leone is fragmented. But relative to the economic constraints placed on Sierra Leone through international financial institutions' (IFI) punitive debt payment requirements – most national monies cannot be spent on health if loan debt remains – fragmentation can also be understood as an adaptive strategy through which health care is made possible in practice. Situating fragmentation within Sierra Leone's postcolonial, global neoliberal economy enables a more balanced assessment for understanding how health systems function under constraints, how actors navigate competing demands, and how futures are negotiated in the present.

The Ebola outbreak in 2014-2016 revealed the deep structural failures stemming from decades of IFI policies, such as structural adjustment, which reduced state spending on health while requiring the privatization of health services in Sierra Leone (Abdullah & Rashid 2017) and quick financializing fixes at the expense of investing in a comprehensive public health system (Erikson 2025). In the aftermath of Ebola, national and international actors once more articulated ambitious visions for health-system strengthening and reform in Sierra Leone, emphasising coordination and alignment with global standards.

The Push and Pull of Synergy and Fragmentation

Here we present interlocutors' reflections on Sierra Leone's Ebola and Covid-19 public health responses. In the selected quotes and even more so in the full interviews, interlocutors raised contextually grounded efforts to manage the health crises with practical common sense in the face of multiple-level hardships. One way interlocutors discussed synergy was through the lens of 'preparedness', where this denoted the ability to build on past pandemic structures to address present pandemics.

The severity of the Ebola outbreak and the inability of the government to quickly contain it was a symptom of fragmented post-war healthcare interventions. Mistrust between citizens and the state grew, engendered by years of neglect and policies that limited access and reinforced inequity (Wright et al. 2015). Yet this mistrust arguably created space in Sierra Leone to forge a different path in its Covid-19 response, which was understood by interlocutors as a negotiation between the State and its residents. Government concerns about potential social unrest, for example, prompted shorter, three-day lockdowns (MIT GOV/LAB et al. 2020). Longer lockdowns were considered infeasible in a context where many people lacked access to running water and stable electricity. Fragmentation and public mistrust, ironically, made social space for departing from global recommendations.

Experiences with Ebola (2014-2016) and Covid-19 (2020-2022) were often narrated through the language of learning, with the Covid-19 response framed as evidence that lessons from Ebola had been successfully institutionalised. Indeed, many interlocutors described the country's Covid-19 response as demonstrations of improved coordination, stronger public health surveillance, and more effective crisis

response, emphasising that Ebola fundamentally reshaped how public health emergencies were understood and managed. For example, in relation to Ebola (2014-2016):

> When the Ebola came, we were ill-prepared and hence the scale and magnitude of the destruction. We have learned to set the pace and consider external intervention as secondary. (Government Interlocutor)
>
> National health policy making is now in sharp focus, and the experiences of the twin shocks of the war and Ebola have contributed to a high sense of building synergy. The post-war context and the post-Ebola health security have enhanced the capacity of national actors to set their own agenda. (Government Interlocutor).
>
> The post-Ebola health security agenda has helped to build a strong policy response mechanism to future disease outbreaks. The system is now better prepared to curb emerging and re-emerging threats. (Government Interlocutor).

The Covid-19 pandemic further turned convention on its head, with Sierra Leone providing a tangible positive example of how a country could leverage past crisis for a desirable future (Erikson 2020). Grounded realities trumped international protocols in unexpected, un-synergized ways. Sierra Leone, for example, was testing for Covid-19 before the United States.

Several interlocutors spoke of how much Sierra Leone's infrastructure to respond to security threats had improved and that the government was able to leverage many of the Ebola structures in the Covid response. Interlocutors cited coordination across ministries, engagement with development partners, and compliance with the International Health Regulations as evidence that Sierra Leone had strengthened its capacity to respond to health emergencies. The donor health security focus translated into increased money, resources, and attention to health security-related activities during and after the Ebola outbreak, resulting in greater domestic prioritisation of this agenda.

For example, from March 2020, which was the same month Covid-19 was designated a pandemic by the World Health Organization, the same Emergency Operations Centre created during Ebola began holding weekly meetings with a cross-section of stakeholders. Renamed the National Covid Emergency Response Centre (NACOVERC) a few months later to reflect the Covid outbreak, much of the structures remained the same, with pre-existing institutional relationships and organization.

Pre-existing organizational structures from the Ebola outbreak made it relatively easy for the government to (re)activate institutional mechanisms and relationships to combat the Covid-19 outbreak. Interlocutors credited the post-Ebola health security agenda with outlining or putting in place institutions able to respond and manage health security issues, such as the Sierra Leone Directorate of Health Security and Emergency, Red Cross, and Office of National Security (ONS). Prevention measures of the Ebola outbreak were useful because they instilled in citizens knowledge of health promotion activities such as frequent handwashing. Although the focus on handwashing eventually died down after Ebola, the habits were reactivated quickly when Covid-19 hit.

While some Ebola-era institutions and practices were reactivated during Covid-19 and the country adopted many international mandates and coordination efforts, Sierra Leone's Covid-19 response did not represent a simple synergism with global protocols. Rather, it reflected selective, adaptive processes shaped by negotiations of local political realities and resource constraints, where fragmentation as diversification *also* functioned as a mechanism for successful government response.

Sierra Leone's Covid-19 management successes – including government-sponsored Covid-19 testing – challenged the long-standing narrative of the Global South as a place of continuous health disaster. Countries in the global North, like the United States, England, Italy, and Spain saw death rates rise quickly and struggled to contain the outbreak. Countries in the global South, including in Sub-Saharan Africa, recorded fewer deaths and were generally commended for good pandemic management (Pailey 2020). Interestingly, public opinion data reinforce the-past-is-present narrative. Afrobarometer surveys

indicated that an overwhelming majority of Sierra Leonean citizens believed the government managed Covid-19 better than Ebola, and that prior epidemic experience contributed to preparedness, with eight in ten citizens reporting that the country's experience with Ebola prepared it to handle Covid-19 (Afrobarometer 2023a). Other research notes Sierra Leone's effective governance and leadership during Covid-19 (Osborne et al. 2025).

Problem of Synergy

The Lancet Commission's definition of synergy assumed that interventions in one health agenda should contribute to strengthening the other two agendas. But in practice, pressures to converge security, healthcare, and prevention led to an increased focus on strengthening the global health security agenda rather than a more comprehensive local health framework envisioned by the Sierra Leonean government. Further, the Commission assumed a stable US global health leadership, which was upended in 2025 when the Trump administration empowered the entrepreneur Elon Musk to dismantle US aid.

The Ebola outbreak had commanded significant global attention, with the UN Security Council convening in September 2014 over a health issue for only the second time, when it called Ebola a 'threat to international peace and security' (BBC News 2014). Like with AIDS before it, global powers grew increasingly concerned that Ebola would breach their own borders. In the words of then US Secretary of Defence Chuck Hagel, 'such events threaten not only the health of our citizens but also geopolitical stability' (Pellerin 2014).

Donor prioritisation of health security, though, was somewhat at odds with the Sierra Leonean government's healthcare agenda that aimed to build a health *system*. In 2010, the government introduced a free health care initiative for pregnant women, infants, and children to age five years (Donnelly 2011), which improved its maternal mortality rates from 1506 death per 100,000 live births in 2000 to 354 in 2023 (World Bank 2026). Its 2017 National Health Sector Strategic Plan's (NHSSP) promoted synergies of competing health provisions (Government of Sierra Leone 2017, p. 13). The Poverty Reduction Strategy Papers, including the Agenda for Prosperity (2013-2018) and the Medium-Term National Development Plan (2019-2023), had prioritized broadening healthcare access and affordability, which is also an explicitly stated goal in the current Medium-Term National Development Plan 2024-2030.

But while the government prioritised the totality of health system reform, as expressed in a multitude of policy documents, donor focus was on health security. Donor visions often reinforced the perceptions of Africans as vectors of disease and framed health as a primarily Global North security issue. Sierra Leone's compliance with the synergy-as-security agenda was a matter of complying with international benchmarks out of fear of losing benefits and as a condition for accessing donor resources. 'Cooperation and coordination can go a long way', one government interlocutor said. 'As a State or as a Ministry, you are bound to comply with international benchmarks. Otherwise, you will stand to lose, and you know what will befall you and your government'.

Attempting synergistic alignment, then, was shaped more by external funding conditions than by domestic priority setting. A government interlocutor noted that '[it] boils down to the power of resources in the hands of donors and the often weakness of government to say no to funding for interventions outside the strategic framework of government'. Another added, 'Donors tag their support to health priorities that fall within their strategic framework. The question often asked is whose reality counts?'.

Synergistic alignment with donor-driven agendas created other problems for Sierra Leonean health reform. Government capacity and funding are limited, and real reform takes time. The speed at which external interventions were imposed means they were not necessarily cohesive or synchronised with pre-existing government priorities or policies, as in the aftermath of Ebola when nearly 20 pieces of legislation were passed on health systems strengthening to meet donor expectations.

Thus, while the Ebola outbreak brought increased attention and donor resources to the health sector, the proliferation of policies and strategies in Sierra Leone in its aftermath was described as a 'mixed blessing', one that resulted in both synergies *and* fragmentation.

> [O]n the one hand, the resources made available in the wake of Ebola have brought new and heretofore unseen attention and energy to areas such as human resources for health (HRH), medical products and information systems … On the other hand, as the health sector has become more diverse, it has also become more fragmented. MoHS staff and resources have not grown in direct proportion to the many new areas of planned activity, and as such the implementation of all of the many sub-sector plans, policies and other documents appears an insurmountable task. (Government of Sierra Leone 2017, p. 17).

In short, developing multiple plans in compliance with international benchmarks over short periods increased what Commission members understood as fragmentation.

Rethinking Sierra Leone's Healthcare Futures: Managed Fragmentation as Resilience?

One government interlocutor pointed out that 'fragmentations are inevitable in the sense that donors provide the much-needed resources and the tendency is that we go for the windfall. Example, the Global Fund was downloaded on us. We went for the money regardless of whether it reflects a priority health need in our country'.

One of the most interesting elements that emerged from our research is that pragmatic, sometimes fragmented, modes of governance, particularly at district and community levels, emerged alongside formal coordination. To ensure feasibility and social acceptance, national guidelines were often adapted to local conditions, modified or selectively enforced. In this way, fragmentation included uneven adherence to national plans, inconsistent enforcement of guidelines, and reliance on community-level adaptation, often reflecting appropriate contextual responsiveness. But it was not a chaotic or always-unintentional fragmentation; it was often managed. During Covid-19, national directives were adapted to local realities, especially when and where livelihoods, food security, mobility, and potential unrest were at stake. The duration and enforcement of local restrictions were shaped by local concerns.

Managed fragmentation, or, as we are thinking about it, diversification, echoes a pre-colonial past, where many African countries, prior to French and British administration, used diversity as a basic survival and lifestyle strategy. Diversification has advantages. But colonial commandeering of African agricultural systems forced a shift to monocropping crops that colonists could export, which greatly reduced local food security, sometimes to the point of famine (Franke & Chasin 1980). Instead of planting 20 different food crops with the expectation that some would come to productive harvest, African countries were forced to turn arable land to inedible crops like cotton, cacao, and coffee.

Call it fragmentation but Sierra Leone's Covid-19 response demonstrated an advantageous responsiveness to the local context. Despite ongoing tensions between international and domestic priorities, with Sierra Leonean interlocutors reporting a sense of international agenda coercion, some communities intentionally went their own way. Even with global health security as the predominant frame, some interlocutors felt they were afforded greater involvement and voice as national policy influencers during the Covid-19 response.

In practice, during Covid-19, short lockdowns, reliance on community leaders, and flexible quarantine arrangements, while seeming to diverge from donor prescriptions and international best practice, nevertheless reflected lessons learned in Sierra Leone from the Ebola outbreak, both about how to control disease and about the social costs of rigid enforcement. Adaptation thus enabled contextual responsiveness, where local actors could balance public health objectives with economic and social

realities. Policy makers and practitioners navigated a hybrid landscape of formal coordination and informal adaptation, where fragmentation enabled experimentation, negotiation, and policy adjustment. This flexibility provided the breathing room for citizens experiencing severe economic constraints.

Political tensions existed, of course. Changes in political leadership in Sierra Leone between the Ebola (APC (All People's Congress) government) and Covid-19 (SLPP (Sierra Leone People's Party) government) outbreaks contributed to partisan tensions during the respective public health responses. For example, although evaluations of SLPP government performance in handling the Covid-19 outbreak were largely positive, interlocutors in non-ruling-party strongholds were six times as likely to say that the government handled the outbreak 'fairly badly' or 'very badly' (13% versus 2%) (Afrobarometer 2023b). Nevertheless, given that in crises vertical top-down approaches are understood as necessary for pandemic prevention (Lees et al. 2022), Sierra Leone's selective uptake in both Ebola and Covid-19 responses provided opportunities for flexibility and adaptive response. As anthropologists Wilkinson and Fairhead argue (2016), Sierra Leone's APC government eased social resistance during the Ebola compared to neighbouring Guinea, lessons remembered when Covid-19 broke out.

Futuring Reform in a World Fragmented by Design

A tendency toward fragmentation may be a design feature, not a bug. For decades, neoliberal dictates influenced healthcare in poor countries in ways that privileged ad-hoc healthcare systems. Private sector organizations were considered superior, giving rise to systems that, indeed, privileged fragmentation. The current health sector in Sierra Leone is a patchwork of health care providers drawn from both the private and public sectors, with preference given by external funders to private actors rather than the government. In our analysis, futuring – 'the identification, creation and dissemination of images of the future shaping the possibility space for action, thus enacting relationships between past, present and future' (Oomen et al. 2022, p. 257) – merges with theorizing about the role human imagination plays and doesn't play in reform (Prainsack 2022).

Because the future is always *becoming*, it cannot be fully measured or assessed in the present. Lip service to ideals of future health reform can easily be paid without doing in the present what is needed for future health outcomes. Although there are significant strides in population health improvements in Sierra Leone, as with the decrease in maternal mortality, the health sector continues to struggle with providing universal healthcare more broadly. Prainsack is useful here: 'Resistance to change is not so much a psychological quality…but the effect of being caught in a web of practices' (Prainsack 2022, p. 21). Rather than health being seen as a social good that a State should provide, the neoliberal web of practices calls for the health sector to be opened to market forces *that are not equity seeking*. Thus, despite calls for change, many health programs remain siloed (Bertone et al. 2018) and inaccessible. The neoliberal emphasis on rolling back the state also helps explain the lack of funding for comprehensive healthcare reform that envisions governments playing a more substantive role.

Given mistrust in state-run accountability, many international donors remain reluctant to engage with government institutions or processes, leading to the establishment of parallel structures, such as a supply chain for drug procurement (M'Cormack-Hale et al. 2019). The web of practices to which Prainsack refers also include global funding and priorities that limit what the country focuses on. The continued international dominance of a health security agenda, for example, fails to advance other local agendas like universal healthcare and health prevention. Crisis framing also makes it difficult to deliberate and critically reflect on alternatives, leading to oversimple approaches destined to have little impact on local health systems building.

Still, humans inherently adapt. Reform happens. As Shepler (2017) notes for Ebola, as the disease spread, lessons were learned about what worked and didn't. Following this, during the Covid-19 response, the government moved away from more formalised institutional structures for containment, and instead, made more use of community care centres, like those that were used during Ebola, allowing those who

could to self-isolate. They also made efforts to intensify social mobilisation at the community level, leveraging traditional, women and religious leaders more (Meriggi & Mobarak 2020). They decentralised to some extent, with District Ebola Response Centres being rolled out in all districts. Again, learning from the Ebola response, the government implemented measures to promote transparency in the use of citizen and donor donations. They also used local data to inform best practices for Sierra Leone, avoiding the longer lockdowns that were considered international best practice. Adaptation meant questioning neoliberal orthodoxy and taking tangible, difficult steps in the present, albeit not achieving the ultimate goal of universal care.

Fragmentation provided spaces for Sierra Leoneans to implement local responses that resonated more with the country's on-the-ground realities. But we acknowledge that triumphant narratives of local know-how oversimplifies the actual on-the-ground dynamics and negotiations that underpinned the response to Covid-19. After an initially positive, life-saving start, Sierra Leone was unable to keep pace with the surge of infectious disease policy initiatives imposed internationally and proposed domestically (Amara et al. 2021). Notwithstanding local agency, northern public health models remain hegemonic and salient. In effect, the future of durable health reform in Sierra Leone remains both imminent and elusive.

Conclusion

The drive to maximize synergies in health reform, as captured by the Lancet Commission's work, was fraught from its inception. As every global health expert knows, each of the three targeted areas are enormous undertakings in and of themselves. Plus, as a starting point, their implementation in countries around the world, rich and poor, is hugely uneven. In practice, there was a hidden ranking of the three calls, likely unintended by the Commission, with health security as first-ranked by global health actors intent on a NIMBYistic infectious disease containment. Embedded in that ranking were not-so-subtle assumptions about 'security for whom and from what' (Rushton 2011). '[M]uch of the controversy around global health security is the result of a feeling in some quarters that this discourse relates primarily to a Western conception of risk, and […] the prioritization of measures designed to contain disease within the developing world rather than […] address the root causes of disease' (Rushton, as cited in Agyepong et al. 2023).

Health futures are continually produced in the present through inherited structures, contested choices, and uneven power relations. Futures invoked in reform discourses are inescapably shaped by histories, financial architectures, and epistemic hierarchies that condition *what* can be envisioned as achievable and for whom. Although local leaders can cast health reform forward into the future, even resounding pasts when diversification proved a lifeline, in countries with significant postcolonial political legacies, old global political and economic ideologies limit how health futures are imagined and enacted (Prainsack 2022).

The synergy-fragmentation binary is insufficient for understanding the dynamics of futuring health system reform in Sierra Leone because it obscured the political and epistemic conditions. Health reforms are not singularly sovereign: political, economic, and social practices reinforced by institutions make reform challenging. 'Try to reform one aspect of this dense structure…and you run into another set of institutions and practices that push back…' (Wagenaar & Prainsack 2020). External impositions, economic precarity, and the limits of trust in government have persistent means of shaping health futuring whether we like it or not.

Complicating the notions of synergy and fragmentation can help illuminate the multiple tensions that emerge when we focus on the future at the expense of the present, reminding us of the need to anticipate the tangible ways context shapes our imaginings of desirable futures. Fragmentation is not a normative good in itself; it can inflect wasteful duplications, life-threatening inequities, and fiscal fragilities. Yet, in contexts of neoliberal domination, where countries can be structurally constrained from

shaping their own priorities, fragmentation may be one of the few pathways through which local actors resist one-size-fits-all prescriptions that will not work and assert contextual relevance in futuring reform.

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Conflicts of interest

The authors declare no conflicts of interest.

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