

Aid instruments for peace- and state-building: Putting the New Deal into practice



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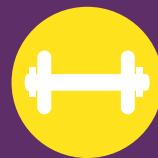
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New Deal case study

Donor support for health workers' salaries during the Ebola outbreak in Liberia

1. Background to the Liberia, the health sector and the 2014/15 Ebola outbreak

Following two periods of civil war (1989-96 and 1999-2003) an August 2003 Peace Deal and elections which followed in 2005 brought new-found stability to Liberia. The period since has seen Liberia make important strides in rebuilding its basic infrastructure and administrative capacity and in achieving development progress.

Amongst the areas where progress has been made in Liberia is with regard to health. During 2000-2013 under-5 mortality in Liberia declined from 21 / 1,000 to 10 / 1,000, and maternal mortality declined from 1,100 per 100,000 live births to 640. This progress has in part been driven by improved investments in health sector. Liberia's 2007 National Health Policy suspended user fees at primary and secondary level and committed the Government to increase health spending. This period has also seen donors significantly increase their spending on the health sector (DuBois and Wake 2015).

However, despite this progress Liberia's current health statistics are still amongst the worst of any country and its health sector remains fragile. The WHO estimates that health care spending of \$86 per person is required to provide a minimum basic package of health services. It also recommends that there be at least one health care worker (doctor, nurse or midwife) for every 439 people in a country. According to the most recent data Liberian Government spending on health is currently equivalent to \$16 person and there are 3472 people for every health worker (DuBois and Wake 2015).

This was the fragile health and broader context in which the 2014/15 Ebola crisis took place. Following the first cases in Guinea in December 2013, its spread to Liberia was confirmed on 31st March. The number of cases increased rapidly in the months that followed and the Liberian Government declared a State of Emergency on 10th August 2015 after Ebola reached the capital Monrovia. The impact of this Ebola outbreak on day to day life in Liberia was significant, with people's movement restricted, major constraints emerging on access to healthcare beyond Ebola-related services, food and fuel running low and the economy slowing (from a growth rate of 5.9% pre-Ebola to 2.2% in 2014 - WB 2014b).

By August 2015 the rapid increases in Ebola cases and then the State of Emergency had stimulated a full blown response from the Government of Liberia and its donors. This response focussed largely on effectively mobilising and resourcing health workers (the focus of this case study), constructing and resourcing specialist treatment centres and efforts to trace Ebola cases.

Following the scale-up in the response to Ebola in Liberia, the number of Ebola cases peaked in September 2015 and the country was declared Ebola free for the first time in May 2005. Following a small outbreak in July 2015, Liberia was again declared Ebola free in September 2015.

2. Introducing the main donor programmes supporting the Liberian Government to manage health workers during the 2014/15 Ebola crisis

As already indicated, one of the most important contributions that donors made in response to Ebola in Liberia (and the other affected countries) was to provide financial assistance to support efforts to mobilise and resource health care workers. A range of governmental and non-governmental actors provided this type of support, including UN agencies and NGOs who were amongst the first to provide such assistance in the first half of 2014. However, reflecting its focus on donor efforts which are consistent with/inspired by the New Deal principles, this case study focuses on those programmes which provided assistance directly to the Liberian Government to support its efforts to mobilise and resource health care workers. The main donor programmes which provided such support included:

- USAID (Emergency Ebola Response Support) – Beginning in September 2014 the US Government (through USAID) provided \$10 million in funding to cover the basic salaries of health-workers over the following 12 months. This support focussed on health workers paid through their bank accounts (rather than in cash). The funding for this project was provided to the Ministry of Finance on a reimbursable basis, with payments made from USAID following verification (involving Uganda's General Auditing Commission and spot checks of facilities) of health worker payrolls and payments being made to health workers. As of December 2015 payments up until

April 2015 had been made, and payment for May-July was being processed (USAID 2015).

- World Bank (Ebola Emergency Response Project) – This project was approved in September 2014, and provided \$105 million in grant support to Guinea, Liberia and Sierra Leone to respond to Ebola. The funding for Liberia totalled \$52 million, with around \$20 million allocated for providing hazard payments (i.e. to incentivise them to remain in post during the crisis) to a wide range of public and private health workers, as well as for covering indemnities in case of death in service. These resources were provided directly to the Government through the Ministry of Finance's financial management unit (World Bank 2014a).
- African Development Bank (Strengthening West Africa's Public Health Systems Response to the Ebola Crisis/SWAPHS) – This project began in September 2014 and provided \$60m to Guinea, Liberia and Sierra Leone to respond to Ebola. The funding for Liberia totalled \$20m, with \$4.5 million provided for hazard payments to a wide range of health workers. The funding was channelled through the WHO to the Ebola Trust Fund which then disbursed funding to the Government of Liberia (AfDB 2014b).

In addition to providing funding to cover Government health worker salaries and hazard payments the World Bank and African Development Bank projects supported the financing and resourcing of expatriate medical doctors, nurses and other medical personnel to support the response effort. These health worker support activities are not the focus of this case study, as they did not directly involve Government health workers and were managed largely outside of the Government's systems.

3. What were the drivers of these programmes?

The financing of health worker salaries has been a long-standing challenge in Liberia with their unions regularly calling for pay increases and strikes. In responding to these pressures the Liberian Government has been constrained by concerns about sparking pay demands across the civil service, low levels of Government revenue and the reluctance of donors to cover such costs.

The 2014/15 Ebola outbreak deepened the challenges relating to health worker pay from two main directions. Firstly, its drag on growth levels led to revenues falling, with total revenues an estimated \$86 million lower as of end 2014 compared to pre-crisis projections (World Bank 2014b). Lower revenues have in turn created challenges for resourcing the public sector, including health workers.

Secondly, health workers faced significant risks in carrying out their work during the outbreak (80 health workers died from the virus by August 2014 – World Bank 2014b), which led to discussions about using financial incentives to encourage them to remain in post. These incentives included top-ups to their salaries (referred to as 'hazard pay') and compensation to be paid to the families of health workers should they die in service. The Liberian Government first used hazard pay early in the outbreak for health workers in Lofa County, where the initial cases were detected. As a result of this policy, demand for hazard pay quickly grew across the health sector as word got out about these payments and the virus spread across the country. By the middle of 2014 there were genuine concerns that the risks facing health workers and unrest over hazard pay would lead to a damaging depletion of health workers, and it was realised that a sector wide approach to hazard pay was required. The result was therefore a further expansion of the resourcing required for health care workers when the Government was least prepared to provide it.

These programmes (collectively worth around \$35 million) therefore emerged at a time when severe pressures were being placed on the Liberian Government to adequately resource health workers in response to Ebola. USAID's programme allowed the Government of Liberia to continue paying basic salaries to health workers, and the World Bank and the African Development Bank assisted in meeting Ebola-related demands for hazard pay.

4. How did these programmes address the New Deal principles?

It is important to note that none of the projects addressed in this case study explicitly identified (in their project documents) the New Deal as a driver. However, the design and implementation of these projects was

consistent with the New Deal's principles (mainly in the TRUST pillar as outlined below:

- Use and strengthen country systems – These programmes all used the Government's systems for implementation. Use of these systems also helped to strengthen in a number of important respects. Firstly, the accountability and oversight involved in USAID's payment of salaries has helped to bring health workers into the formal pay system, and also to remove ghost workers for the payroll. Secondly, the delivery of hazard payments through the Government and using its hazard pay scales helped to harmonise the hazard pay system.
- Revenue and services – These programme were critical in helping to maintain health services (to address Ebola and other health issues) during the Ebola outbreak. A wide range of health workers were supported, including the Government's medical staff, the staff of Emergency Treatment Units (ETUs) and first responders to cases of Ebola. Without this support there may well have been a damaging collapse in levels of service delivery, due to limited local resources and an unwillingness of health workers to remain in post.

One factor which may have contributed to the limited influence of the New Deal over these programmes is that it was reported that the Government did not effectively bring attention to New Deal commitments during the dialogue with donors over the Ebola response.

5. Programme impacts and challenges

These programmes have collectively reached a very significant number of health workers and there are also indications that they may have played a role in reducing Ebola infection rates.

Based on data received from USAID, the number of health workers whose salaries were paid through its Emergency Ebola Response Support project increased from 3,710 in its first month to over 4,000 per month by the end of the project. The project was able to reach an increasing number of health workers as additional health workers were added to the formal payment over the course of its implementation. This is an outcome which was incentivised by USAID's decision to only

support health workers who were paid through their bank accounts. In addition, the audits carried out to verify payroll numbers and payments to health workers resulted in the elimination of a number of ghost workers (including 50 in one month alone) from the health payroll. These outcomes will have made a modest contribution to efforts to improve the accountability and sustainability of health worker pay.

The World Bank's Ebola Emergency Response Project and the African Development Bank's SWAPHS project are reported to have provided hazard payments to 7,500 health workers (World Bank 2014b). The World Bank also played an important role in supporting the Government of Liberia to negotiate the system of hazard pay with health workers, which in turn

It is also the case that these programmes may have made an important contribution to reducing and eradicating Ebola. These programmes began at the peak of the crisis (in terms of the number of cases), following which cases declined. There is no evidence currently available linking these programmes to the decline in cases. However, given the central role health workers played in the Ebola response these programmes are likely to have made a significant contribution to this outcome.

Finally, it is important to reference some of the challenges that were faced in effectively implementing these programmes. Firstly, as has been highlighted with regard to the Ebola response in general (DuBois and Wake 2015), it is relevant to note that these programmes only began six months after the first Ebola cases were detected in Liberia, and therefore could have made a more timely contribution to tackling Ebola if they had emerged earlier. Secondly, there were some delays in making hazard payments, which were only completed in September/October 2015, following protests from health workers in response to these delays. These delays were caused by bureaucratic challenges on the side of both the Government and donors.

6. Lessons learnt

The experiences of this project provide important lessons for other projects being implemented in fragile states:

- Timely responses - It is important for development partners to respond in a timely way to development challenges, especially in the context of emergencies such as Ebola. More timely responses require a clear articulation of demand from recipients, and development partners to closely monitor local context, work flexibly with their available funding channels and reduce the bureaucracy relating to project development.
- Promoting the New Deal - Partner governments need to more effectively raise the profile of the New Deal and use it to leverage change in the policies and practices of donors.
- There are always opportunities to work through and strengthen systems – USAID's approach to supporting health worker salaries illustrates how it is possible to use and strengthen systems even in fragile states in the context of an emergency. Working in this way ensures that long term impacts are pursued alongside addressing emergency needs.

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g7plus

Address: Kobe House 2nd Floor, Ministry of Finance,
Avenida Presidente Nicolau Lobato, Dili, Timor - Leste

Telephone: (+670) 331 0126

E-mail: g7plus.secretariat@gmail.com

Facebook: www.facebook.com/g7plus

Twitter: [@g7plus](https://twitter.com/g7plus)

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