GOVERNMENT RESOURCE ACCOUNTABILITY DURING THE COVID-19 PANDEMIC

A REPORT FROM

14 COUNTRIES

Prepared as Part of a Global and Country-Level Analysis in 18 Countries

DECEMBER 2022

ITPC
INTERNATIONAL TREATMENT PREPAREDNESS COALITION

This is the 13th "Missing the Target" *report produced by ITPC since 2005 and the first MTT report to engage with government resource accountability during the COVID-19 pandemic. As with previous MTT reports, this report highlights the experience and perspectives of advocates in multiple countries to document progress toward global commitments for health, development, and human rights.*

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ABOUT

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The International Treatment Preparedness Coalition (ITPC) is a global network of people living with HIV and community activists working to achieve universal access to optimal HIV treatment for those in need. Formed in 2003, ITPC actively advocates for treatment access across the globe through the focus of three strategic pillars:

- Make Medicines Affordable
- Watch What Matters
- Build Resilient Communities

To learn more about ITPC, visit itpcglobal.org

ABOUT WATCH WHAT MATTERS

Watch What Matters is a community monitoring and research initiative that gathers data on access to and quality of HIV treatment globally. It fulfils one of ITPC's core strategic objectives: to ensure that those in power remain accountable to the communities they serve. Watch What Matters aims to streamline and standardize treatment access data collected by communities—helping ensure that data is no longer collected in a fragmented way and that it reflects the issues and questions that are most important to people living with and affected by HIV. It relies on a unique model that empowers communities to systematically, routinely collect and analyze qualitative and quantitative data on access barriers and use it to guide advocacy efforts and promote accountability.

To learn more about Watch What Matters and ITPC's community-led monitoring work, visit WatchWhatMatters.org.

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Matahari Global Solutions
Matahari Global Solutions is a team of health experts working with Global South partners to monitor and evaluate global health initiatives, produce in-depth analysis, build strategies, and increase visibility about country-level challenges in access to health.

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Thank you to all the people living with HIV who shared their experiences and thoughts to inform the report.

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SUMMARY

From April to July 2022, Matahari Global Solutions conducted a mixed-methods mapping exercise in 14 countries and territories to draw up a situation analysis on access to COVID-19 tools. These countries were Bangladesh, Democratic Republic of the Congo (DRC), Haiti, Jamaica, Liberia, Madagascar, Nepal, Nigeria, Perú, Senegal, Somalia (and de facto state Somaliland), Uganda, and Ukraine. The final report is accessible here.

The methods utilized a mapping tool to help consultants plot data points, drawing from a desk review of secondary data, interviews with key informants from WHO offices, Ministries of Health, and civil society organizations, as well as working through local consultants in DRC, Madagascar, and Nigeria to connect with local healthcare workers (including community health workers) and members of communities in rural areas to create a snapshot of access to COVID-19 tools in these areas. This report is published here. Several points of contention emerged from our research, suggesting the need for robust government resource accountability and community-led advocacy to resolve key barriers to equitable access and effective responses.

KEY FINDINGS AND RECOMMENDATIONS

Key Findings

- In 13 out of 14 countries surveyed, the COVID-19 response was held back by inadequate investments in frontline health workers. Community health workers were typically unpaid, and formally trained health workers experienced chronically poor remuneration and serious delays or interruptions in payments. These problems existed before the COVID-19 pandemic, but persisted despite billions spent on international assistance.
- Key commodities, including rapid antigen tests, were not available in contexts where they were needed as a crucial public health tool, such as in conflict settings or with mobile and migrant populations. Further, problems in procurement and supply management and restrictions on who could deliver essential diagnostics, vaccines, and medicines prevented efficient and effective delivery of these commodities to vulnerable countries and communities, worsening global inequities.
- Global entities, including WHO and the G20 ACT-A (Access to COVID-19 Tools Accelerator) Initiative, persistently failed to include expertise from low- and middle-income countries in their strategies, undermining the COVID-19 response. There is little evidence that proposed mechanisms like the World Bank-hosted Pandemic Preparedness and Response Financial Intermediary Fund (FIF) are learning from these lessons.

Recommendations

- Fair remuneration for all healthcare workers, including community health workers, must be a top priority for governments, funders, and other stakeholders investing in future pandemic preparedness and response.
- Community advocacy based on monitoring and evidence-gathering at the local level is crucial for identifying gaps, mobilizing solutions, and ensuring accountability for a wider audience. Community-led monitoring must be resourced and recognized as a core component of pandemic preparedness and response.
- Expertise and insights from low- and middle-income countries must be integrated into governance and daily work of any and all international and regional pandemic response mechanisms.

A REPORT FROM 14 COUNTRIES

Non-payment, delayed payment, and poor remuneration scales for health workers

Interviews in Haiti and DRC found poor remuneration practices for formally trained health workers. In all countries (except for Liberia), they found no remuneration for community health workers. Nurses in North Kivu in eastern DRC reported an official monthly salary of US$80 per month; however, they stated that they had not been paid for some time. This is consistent with reports at the national level, and unpaid healthcare workers have chosen to protest unpaid salaries and have initiated strikes.[1] Due to the lack of payment, healthcare worker strikes have occurred on several occasions, disrupting provision of health service provision and resulting in distrust of government.

On this latter point, experts Bousquet and Fernandez-Tarranco state:[2]

Mburano Kitsa, a community health worker in Kimoka, North Kivu, DRC

Basic services like health, social protection and education are of course critical in themselves, but they are also the main ways that people interact directly with the state, including local institutions. They are the primary vehicle to create trust and confidence in governments.

In **Haiti**, the state remunerates health workers very poorly. There are other challenges, such as the difficulty in conducting bank transfers, making simple and timely payments a challenge.

If you work in health in Haiti, it is for love and not for the pay. We are quite badly paid. If you work in Haiti, normally it is the state that pays you. If you work in a private hospital, it is another system. Sometimes doctors and nurses can go six months, a year, without receiving remuneration. Lower bands have it worse; they don't really have access to remuneration. Sometimes we are forced to leave the country if we want a better pay.

—Dr Marie Delcarme Petit-Homme, clinician, Haiti

Poor remuneration was also documented in **Nigeria**, where healthcare workers told us that being asked to do COVID-19 tests in addition to existing work was a burden—and that there was poor motivation to do additional work on account of poor income levels.

In **DRC**, the backlog of healthcare workers' salaries being paid has added to their existing distrust of the government.[3] Respondents indicated that the government of DRC has made the decision to pay community health workers working to support the rollout of COVID-19 vaccinations.[4] However, questions remain about the long-term sustainability of this decision and whether it will be institutionalized once the acute phase of the pandemic has subsided. Of note was

the testimony of a community health worker (CHW) working in a rural area in North Kivu:

I am vaccinated with the J&J vaccine and the whole process took no more than 30 minutes. I got vaccinated to be an example to other people who I will be educating.

—Mburano Kitsa, community health worker working in Kimoka, North Kivu province, eastern DRC

This testimony illustrates how CHWs who know their context and community's concerns can be effective at increasing vaccine uptake.

This is also illustrated in examples from **Liberia**, where 4,000 CHWs are working across its 15 counties, acting as "a crucial first line of defense against infectious diseases."[5] According to an April 2022 article, these CHWs are paid and receive months of training, including on malaria diagnosis and first aid.[6]

In several contexts, community health workers have helped drive rapid testing within communities.[7] In **Jamaica**, however, where tests remain accessible only to those with financial ability, community health workers were not allowed to deploy rapid antigen tests within communities.[8]

The Government of Jamaica missed a huge opportunity to make testing more accessible and equitable when they refused to allow community health workers to do testing. This in stark contrast to the amazing work done by community health workers in other parts of Latin America and the Caribbean and countries as diverse as Bangladesh and Rwanda where community health workers became the backbone of the COVID responses across their countries.

—Carolyn Gomes, Co-Chair of the Caribbean Centre for Human Right)

Given their important role in increasing vaccine uptake, delivering self-tests, and addressing misinformation and the legitimate concerns of communities, CHWs being unpaid is unthinkable and a violation of Article 23 of the Universal Declaration on Human Rights; it states that everyone has a right to "just and favourable conditions of work" and "the right to equal pay for equal work."[9] These unfair pay conditions create uncertainty and instability for community health workers and have been referred to by one HIV community expert, Dr Vuyiseka Dubula, as "modern day slavery."[10]

There remains a lack of accountability on CHW salaries from governments, donors, policymakers, and global health academics—as found in a recent critique on the Lancet Global Health Commission on financing primary healthcare. It states that paying community health workers is still a health "financing policy choice", which leaves the decision about remuneration with policymakers, rather than establishing compensation, as the norm. The authors, including Madeleine Ballard from the Community Health Impact Coalition, write of the choice to pay or not pay community health workers—"is the same true of doctors? Nurses?"[11]—and urge that all parties focus on resolving this issue. Ultimately, all governments, donors, philanthropies, and NGOs must address this critical gap; without fair remuneration for all healthcare workers, including community health workers, future pandemic response will remain piecemeal and incomplete.

Underinvestment in Oxygen Plant Production and Maintenance

Our examination of 14 countries and territories from 2021 to the time of publication shows that while some new investments have been made to install new plants and increase access to liquid oxygen in selected countries, poor planning on oxygen and under-resourcing of maintenance for existing plants and mobile oxygen concentrators remain. In **Peru**, which had the highest oxygen

need of countries examined, at 58,217m^3 per day, oxygen maintenance responsibilities have been decentralized to regions—without adequately accounting for heterogeneity in technical capacity and budgets. In addition, oxygen projections have been plotted with oxygen needs between waves rather than at COVID-19 peaks, rendering an inaccurate picture of true oxygen needs.[12]

Haiti, Madagascar, and Nigeria reported having faulty or broken oxygen plants although, due to non-transparency of data, more countries are likely to be in the same situation. In **Nigeria**, the National Agency for the Control of AIDS issued an August 2021 tender[13] for the repair of 31 oxygen plants across the country, from the National Hospital in Abuja to the University of Port Harcourt oxygen plant in Rivers state in southern Nigeria. At the time of writing, there has been a threefold increase in daily oxygen need in Nigeria (from 2,601m^3 in March 2022 to 6,717m^3 in July 2022). However, the reasons for this remain unclear. We spoke to a Public Health Officer at WHO Nigeria, who told us about repair work done to the oxygen plant at the Federal Medical Centre (FMC) in Gombe, northeastern Nigeria—but that there are frequent breakdowns:

The FMC Gombe oxygen plant has been working recently but not at full capacity after the repair work. The oxygen plant breaks down whenever there's high demand and it needs upgrading in other wards and further installation of another one with regular maintenance.

—Public Health Officer, WHO Nigeria

Our data suggest the need for robust and transparent multiyear oxygen plans. **Liberia**, having the lowest plotted oxygen needs out of all countries examined, at 137m^3 per day, has taken a step in the right direction with the 2021-2024 National Roadmap to Increase Access to Medical

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Oxygen in Liberia.[14] The plan includes a national database of oxygen equipment inventory, routine supervision of health facilities, and updating of donation guidelines to include medical oxygen. Implementation of these could prove to be best practice for other countries in ensuring oxygen access for the long-term.

Infrastructure and Commodities Gaps for Pandemic Response

Our research exposed that there are several gaps in supplies that created inequitable access to COVID-19 tools. In DRC, our local partner for this project, the clinician-led CSO, COSAMED, reported that there were complete stockouts of antigen rapid diagnostic tests (AgRDTs)s in North Kivu, leaving more than 20,000 households displaced due to conflict; due to previous volcanic eruptions in Rutshuru and Nyiragongo, they were without access to screening tests. As a result of discussions facilitated by our research between Dr Elia Badjo, Founder of COSAMED, and Sanjay Sarin, Vice President of Access with the Foundation for Innovative Diagnostics (FIND), supplies of AgRDTs were arranged for deployment.

In Haiti, where there is widespread insecurity and displacement due to gang violence, earthquakes, floods, and fuel shortages, Dr Marie Delcarme Petit-Homme told us of poor access to personal protective equipment (PPE) and other equipment:

There are so many flaws in our healthcare system. There are inadequate materials. In the emergency rooms sometimes, you cannot find gloves, and there is insufficient equipment.

In both of these contexts, pandemic response must involve a conflict lens,[15] a perspective that was largely ignored at the global level. Communities and community service organizations (CSOs) can play an essential role in distilling information from countries, highlighting key gaps, and not only holding governments accountable, but also facilitating key partnerships that increase access to pandemic tools.

Overall, access to rapid antigen testing remains inadequate across all 14 countries and territories examined—and the majority of countries examined do not have access to rapid self-testing, unlike in several countries in the Global North where self-testing is provided for free. This gap was further accentuated by the late issuance of WHO guidance on self-tests, issued in March 2022,[16] when countries in the Global North, which predominantly rely on the guidance of their own scientific decision-makers, had deployed self-tests, often for free, widely in their communities.

The rapid test equity gap is especially problematic for countries with large proportions of nomadic populations. In **Somalia**, where 25% of the population is nomadic, serious challenges to testing equity remain. Notable challenges are that PCR is ill-suited to nomadic populations and there are insufficient numbers in the health workforce to deploy rapid tests to hard-to-reach areas.

Twenty-five percent of the people in Somalia are nomadic (and) are moving from one place to another. Unless we have mobile facilities like laboratories and mobile health services, we cannot cover these nomadic populations. To cover these people living in hard-to-reach areas, we need to have a separate strategy … laboratories close (to) … where they're living… rapid tests are ideally suitable for these types of conditions. But having deployment of rapid diagnostic tests will be most useful if we have a mobile health workforce who is deployed in these places to make sure that all containment and mitigation measures are also put in place. In Somalia, our workforce density is very low because many skilled health workers have migrated; thus the density of health workforce in Somalia is less than one per thousand when it should be four to five times higher. This workforce issue comes with another layer of funding needs.

(Dr Mamunur Rahman Malik,
WHO Representative for Somalia)

Effective pandemic responses must be interlinked with ongoing efforts to resolve and mitigate the impact of conflict and poverty and an in-depth understanding of local context. Dr Malik illustrates a number of key areas where Somalia is underfunded, including commodities supply, workforce support, and mobile teams. Community advocacy is the first step towards increasing visibility and thereon accountability on these issues for a wider audience.

Implications for Global Health Architecture and Resource Accountability

The ACT-Accelerator[17] was a largely Global North-led initiative with poor involvement of low- and middle-income countries (LMICs) in weekly discussions throughout the pandemic. This snippet from our mapping project in 14 countries and territories and the testimonials of LMIC experts therein could have gone a long way towards informing and underlining pandemic response at the global level.

One example lies in the Health Systems and Response Connector, which at the start of the ACT-Accelerator involved only PPE and oxygen. The latter is a therapeutic and was subsequently transferred to the Therapeutics pillar of the ACT-A. LMIC and community expertise at the

early stages could have informed the Connector of the numerous health systems needs and corresponding resources required. In addition, CHW salaries should have been clearly prioritized within pandemic plans and, going forward, should be a key element of country strategic plans. While countries may be daunted by the prospect of giving CHWs salaries, it can be argued that: 1) acknowledging the gap is a first step; and 2) these may be financed through a multitude of different mechanisms.

Involvement of LMIC experts, including community experts in a form of community monitoring, also improves resource accountability during pandemics. The example of our research and partnerships with COSAMED resulting in identification of rapid testing gaps and stockouts is a prime example of this—community-led monitoring increases accountability, equity, and reach of interventions.

Unfortunately, the lessons from the ACT-Accelerator at the time of writing do not seem to be replicated by additional pandemic preparedness and response organs, such as the World Bank's Financial Intermediary Fund (FIF). The FIF is described as a platform "designed to mobilize significant financial support and engender collective action for development priorities, often contributing to global public goods" and to "focus and sustain much-needed high-level attention on strengthening PPR" during peace time.[18] It could be described as a grant and loan disbursement mechanism for pandemic preparedness—or an ACT-Accelerator for in between acute phases of pandemics. Governance discussions for the FIF continue to occur without communities and civil society, leaving global health agencies and sympathetic governments to make representations for CSOs on their behalf. It remains unclear whether the World Bank will incorporate suggestions of ACT-Accelerator CSOs in its June 2020 white paper,[19] including voting seats on the Board of the FIF. At the time of writing, anecdotes indicate there may be two Board seats for CSOs, but this remains unresolved given the opacity of discussions.

It remains essential that LMIC expertise and insight, as displayed above, be integrated into governance and daily work of any pandemic response mechanism, whether at the global, regional, or national levels. Exclusion of this will cause failure at the worst and inequity, as seen in the COVID-19 response, replicated for future pandemics. Accountability for future pandemics can only occur through democratization, including by ensuring that LMIC experts and CSOs are part of governance and ensuring that there are robust in-country plans.

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