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PSI TRADE UNION RESPONSE TO THE EBOLA VIRUS DISEASE

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INTRODUCTION: A GLOBAL VIEW ON THE IMPACT OF EBOLA

From the moment the Ebola Virus Disease emerged in Guinea and made its way through Sierra Leone and Liberia, with short but adequately repressed upheavals in Senegal and Nigeria, it affected 28.616 people and caused 11.310 deaths.
The outbreak caused enormous economic damage to the countries affected, led to travel restrictions, the closure of schools and many other social services, destruction of jobs and the inability of people to make their livelihoods. The World Bank estimates that the economic impact for the three outbreak countries in 2014 alone is over $500 million in losses, about 5% of their combined Gross Domestic Product (GDP).

The fact that the disease could spread so uncontrollable in Guinea, Liberia and Sierra Leone revealed the structural and systemic weaknesses of the health systems in these countries, caused by decades of lack of investment in public sector health systems and the totally inadequate attempts to redevelopment following the end of the civil conflicts in Liberia and Sierra Leone. Moreover, these weaknesses have a direct impact on the surrounding countries and even countries much further away, with EVD infections and deaths reported in the United States and Spain.

The immediate general response to the EVD outbreak was essentially “technical” and “logistical” (mobilizing external assistance, providing resources, infrastructure etc.). However, such responses cannot address the structural and long-term political problem: non-functioning public health systems lacking in decent working conditions and totally inadequate in providing universal coverage, let alone confronting a major health disaster.

The deplorable state of the health care sectors caused an unprecedented number of medical staff to get infected by the disease. Health care workers and nurses were confronted with inadequate personal protective equipment (PPE), unsafe working environments, substandard infrastructure, over-exposure to hazardous environments, structural understaffing and a complete lack of sufficient resources to deal with the scale of infections.

More than 500 health workers died of Ebola due to the poor working conditions and inadequate safety measures, which only aggravated the health situation in the three most affected countries.

A study of the World Bank Group indicated that “*as of May 2015, 0.11% of Liberia’s entire general population had died due to Ebola, as compared with 8.07% of its health workers, defined in the study as doctors, nurses and midwives. In Sierra Leone, the loss was 0.06% of the general population compared with 6.85% of the health workers, while 0.02% of Guinea’s overall population had died compared with 1.45% of all health workers. According to the report this translates into a 10% reduction in doctors*

in Liberia (which only had about 50 to start) and an 8% reduction in nurses and midwives. In Sierra Leone, it means a 5% reduction in doctors and a 7% reduction in nurses and midwives. In Guinea, the reduction is smaller, 2% for doctors and 1% for nurses."

To make matters worse, those fighting in the frontline got seriously underpaid. Regardless the big amounts of money directed to the three Ebola countries, health workers often went without pay and risk allowances, and were torn between fighting for their rights or fighting the disease. Furthermore, Public Services International (PSI) has received reports that health workers who have died are not being covered by (already severely inadequate) social security systems and their families (if they have survived) are left destitute.

It was furthermore striking that in the three most affected countries, Sierra Leone, Guinea and Liberia, unions of public sector workers have been almost absent from the development of the action plans. The fact that unions can play a positive role in the elaboration of a response is nonetheless proven by Nigeria, where unions gave early warnings and ultimately government and health care unions worked closely together to successfully stop the spread of the disease. The health sector unions represent the health care workers who are the experts on fighting Ebola and therefore have the best insights into the needs of a strong national health care sector. As one of them stated: "We are the ones who wear the shoe and therefore know best where it doesn't fit".

TRADE UNION RESPONSE: THE EBOLA RESPONSE STRATEGY

At the start of the Ebola crisis, PSI was contacted by its affiliates from the three most affected countries with the alarming news that health workers were dying on the work floor. In order to support its affiliates and bring the political nature of the problem to the forefront, PSI and its affiliates in the region, united in WAHSUN, the West-African Health Sector Unions Network, launched together the **Ebola Response Strategy** aimed at **empowering unions** through research, capacity building and exchange between unions, so they can play an **active role in the decision-making processes** and advocate quality public health systems, better working conditions for health care workers, universal health coverage, social security systems, etc. We are trying to work together with a variety of actors of civil society who share our views and thus create a large network of support.

The different pillars of the Strategy

Research and exchange

Unions inside WAHSUN are exchanging information and lessons learned, not only on dealing with Ebola, but also on the elaboration of social security systems and universal health care. An important aspect in this is the development of fair taxation systems. Tax evasion and tax avoidance currently drain billions in resources out of Africa, money that states need to increase their budgets and finance the development of strong public social services and public social security systems.

Respect for union rights and Social Dialogue

It was in fact health workers themselves who raised the issue of Ebola early in 2014 – yet these voices were not heard primarily because of the lack of a functioning structure for dialogue in the countries themselves. Numerous examples show that a strong social dialogue can effectively make a difference. In Nigeria, unions gave early warnings and ultimately government and health care unions worked closely together to successfully stop the spread of the disease. In Sierra Leone and Guinea however, social dialogue is weak, whereas in Liberia, trade unions in the public sector remain illegal. Getting health care workers involved in the recovery process will be the greatest challenge of the trade union reaction.

Outreach

Various civil society organisations and NGOs are aware of the importance of quality public services and mechanisms for participation in a democracy. The creation of a large platform of likeminded organisations will make our demands and opinions widely supported. United we will have a stronger voice in the debate.

Lobby

The unions will lobby national governments, regional and international institutions, donors, etc., to explain their positions, clarify the difficulties that are experienced by the health care workers, the structural problems in the health care systems and the possible solutions and alternatives.

Communication

Our trade union strategy wants to give a voice to health care workers. They will tell their story, testify about the difficulties they encounter while trying to do their job and give their suggestions for solutions.

WORK ON THE GROUND: 3 NATIONAL ACTION PLANS

Working on the action plan in Guinea

The kick off of our activities was a big consultation meeting in Ghana with the health unions from the three most affected countries Guinea, Liberia and Sierra Leone. After an exercise on union challenges, opportunities and priorities, the unions started working on the analysis of their own national situation and the elaboration of a national action plan for their union.

Once returned in their respective countries, a lot of internal awareness raising and consultation inside the unions had to be done. The Strategy is a different way of working, it steps outside the known union environment and reaches out to other kinds of organisations. To make this change of mentality, a lot of internal discussions with the rank and file is necessary. A second reason for the internal consultations was the input on the local situations from the members, so the National Action Plans truly cover the challenges and realities on the work floor.

In January, PSI visited the three countries and the National Action Plans were finalised, all three focusing on collection of information and elaboration of argumentation, networking and lobby work, linked to the themes of working conditions, social security, qualitative public health systems and crisis preparedness.

Guinea, already started in 2015 with laying out the first contacts with Civil Society Organisations (CSOs). This year, an internal union vision will be elaborated, based on which these contacts will be further deepened and a closer collaboration will be set up where possible. Together with those organisations who share the same views on what is needed for the realisation of quality public health systems, different lobby instruments will be elaborated and applied. The lobby work will focus on initiatives to be included in decision making bodies and awareness raising on the networks' common demands.

A whole part in the National Action Plan is dedicated to Social Security: a survey will be done on what support the families of the deceased health workers did or did not receive from the government. Based on this, activities will be elaborated to start up support for the families. A last big activity is the organisation of a National Forum on Social security with participation of a large amount of players, from the CSOs that are part of the network to contacts elaborated during the lobby activities.

In **Sierra Leone**, the health union is already in close contact with a whole range of CSOs active on health. In the context of the Ebola Response Strategy, a monthly meeting has been set up, in order to discuss together the many challenges the country faces in the health department, linked to decent working conditions and a qualitative service to all. Given these close contacts, a selection of people representing various health CSOs were included in the Project Management Committee (PMC) and the National Action Plan was elaborated together. This resulted in an NAP that not only includes Health workers and union members for the collection of information and awareness raising, but also representatives of the CSOs on district level, Village Development Committees and Community Health Workers' Committees.

In **Liberia**, unions are faced with an additional challenge: the right to organise is not recognised in the Public Sector and the unions and associations are confronted with serious anti-union behaviour from the government. So next to the different pillars and themes of the strategy, their NAP includes an additional part on TUR with activities on union certification and the reinstatement of dismissed union leaders. First action was an official complaint against the Liberian government at the ILO Committee of Freedom and Association.

Positive in Liberia is the collaboration between the different PSI affiliates, so not only the two health unions NAHWAL and NPSHWUL of respectively the public and the private health sector are represented, but also LUNAST of the education sector and NTUPAW of the public sector workers are participating. This combined union expertise gave them a much better view on which state actors to target, so various visits to the relevant committees of parliament and ministries have already been planned.

THE SURVEY: MAPPING MISSING WAGES, HAZARD FEES AND FAMILY SUPPORT

Presenting the survey to the health care workers in Liberia

In the first stage of the Strategy, the health unions are focusing on the collection of information, in order to elaborate their union demands on proven data. An important instrument in this is the survey, which is used to collect data on payment of the wages and hazard fees of health care workers and the financial support for the families of deceased health care workers, since serious problems were detected on this in all three countries. Interesting fact: the fund for the hazard fees was delivered by the World Bank, but it is not always clear where the money exactly was used for.

In **Sierra Leone**, hazard payments were being paid as a result of intense negotiations between unions and the relevant government associations. The volunteer payment and the hazard pay falls partly under the responsibility of the ministry of Health and Sanitation, who is responsible for the elaboration of the list, and partly of the National Ebola Response Centre (NERC), who is responsible for the payments. However, after the Military authorities took over the national response, everything was interrupted, resulting in names of essential staff members being removed from the pay list and serious delays in the payments. This led to spontaneous strikes by staff members, but unions and government together made sure services were not interrupted.

There were also a lot of problems with the payment of wages of HCWs. Only in centres operated by external organisations such as DFID and NGOs, payment was secured, since they pay for the employees in their own centres. Because of the many problems, and to prevent health care workers to go on strike or just not showing up at work anymore, UNDP became the technical advisor for the development of the system for the payments of the National Ebola Response Centres. This includes control on the lists and ensure the right people get paid on the right time. The UNDP staff also observed irregularities: in some localities, every month certain names were again removed or added to the list.

Also in **Liberia**, unions worked on the payment of a hazard fee. Unfortunately, irrespective of the agreement of August 9, 2014 between President Johnson Sirleaf and the Health workers, not all health workers received their hazard pay. Many of the public servants only received a portion of the amount they are entitled to, while nearly all

private health workers did not receive their payments yet. Problems still exist on the payments of wages too. These problems are totally being ignored by the Liberian government while the Ministry of Health is fully aware of the fact that some health workers' bank accounts got wrongly entered into the system and therefore did not receive any financial compensation. Some health workers' names were omitted and because of the bad organisation of data, the government by occasion had to pay workers three or four months due wage and / or Hazard Pay at a time. The government never gave the health care workers enough time to deposit a claim about the non-payment of salary and hazard pay. The deadline was given too short a notice for most of the Health Workers assigned in hard to reach areas. Many did not even hear about it before the deadline was over.

After the Liberian government proudly stated every health worker had been paid, NAHWAL collected bank statements of health workers that prove they did not receive at all or not fully the promised and negotiated Ebola Hazard Pay. The fact that the Liberian government is ignoring these challenges, raises a lot of questions for the future. Both Liberian health unions are very concerned about this, certainly since the payments of health workers in the private sector still have to be made.

So although the government claims to have paid all Public Health Workers, Contact Tracers, & Response team workers, unions want to know for a fact how many Health Care Providers were paid and is demanding the creation of a neutral body with representatives from both GOL & Workers' Leadership, in order to validate the figures. Also, there should be an extension of the deadline for claim declaration in order to allow those in hard to reach places to hear and respond to the call, and give also to those in the Private Sector the chance to check their payments once they're finally made.

LOBBY: VISITS IN THE THREE MOST AFFECTED COUNTRIES AND THE UNITED STATES

Participating in the UN Ebola Conference

Highlight of 2015 was a range of lobby activities, including lobby weeks in Liberia, Sierra Leone and Guinea, but also with a wide range of activities in the United States, at the heart of international policy making.

The first big initiative was the participation of a small PSI delegation, with representatives of PSI, the Nigerian Labour Congress and 1199, the health union of SEIU (Service Employees International Union, an American affiliate of PSI) in New York, to the UN Ebola Conference at the beginning of July 2015. With Dr. Goss, the PSI project coordinator, PSI even had a speaker in one of the panels. Afterwards, a big awareness raising activity on the Ebola Response Strategy was organised by 1199 for its militants.

For the second step in the lobby activities, Public Services International and SEUI 1199 organized together in October 2015 a series of lobby and awareness raising activities, aimed at clarifying the political problems linked to the Ebola Virus disease. The delegation comprised or representatives of the health care unions of Liberia and Sierra Leone and one representative of the Ghanaian Health Sector Workers Union, one of the driving forces of the West-African Health Sector Unions Network. The members of the delegation denounced the structural problems of their national health care sectors, the working conditions of the Health workers and the refusal of the governments to involve the workers in the elaboration of recovery plans. Only the Ghanaian union has been able to work on an Ebola plan in collaboration with its government.

Part of the delegation started in LA for some awareness raising activities with the Californian health branch of SEIU, the other part started in Washington with advocacy and lobby activities towards the Solidarity Center, USAID, World Bank, with Karen Bass, ranking Democrat on the Foreign Affairs Subcommittee on Africa, and Rear Admiral Scott Giberson, U.S. Assistant Surgeon General.

In the second part of the trip, both parts reunited in New York for awareness raising activities in a wide range of health institutions, including an exchange on Ebola preparedness with the staff of an American Ebola unit.

Afterwards, it was time to start working in the three countries themselves, where we targeted different players in the sector: international institutions, NGO's, donors, but also CSO. With our visits, we wanted to get the voice of the workers out and denounce the fact that unions are not included in the discussions on the recovery plan. Thereby, we hoped to create some long term collaborations and support for better working conditions and the elaboration of a qualitative health care system.

The message focused on crisis preparedness, and therefore the need to make structural changes in the health care sector, the link between working conditions and qualitative health services, the role of trade unions in the elaboration of post Ebola policies and the remaining problems in the area of wages of health workers and support for families of deceased HCWs. In Liberia, the disrespect of the government for the ILO conventions on the right to organize and trade union rights was added to the message.

We had some good encounters and in multiple locations, we met with representatives of the EU, of different UN programmes and agencies such as WHO, UNFPA, UNDP and World Bank, of the ministries of Health and the WAHO (West African Health Organisation) focal point, and with the historical donor in every country, respectively USAID (Liberia), DFID (Sierra Leone) and Agence Française de Développement (Guinea). In Liberia, we managed to get the subject of wages for HCWs and support for the families on the agenda of the Protection Partner Forum, despite the attempts of the presiding deputy minister of Justice to pass over this topic.

LIBERIA: TRADE UNION RIGHTS UNDER ATTACK

Martha C. Morris and George Poe Williams

Liberia, with its 3 health workers per 10,000 people while ILO calculations estimate 41 to be necessary for an adequate health care system, was the third in the chain of 3 sisterly nations of the Mano River basin to be hit by the Ebola crisis. Liberia has been the worst-hit, with more than 4,800 dead and 10,672 becoming infected. According to the WHO, at the peak of transmission, during August and September 2014, Liberia was reporting between 300 and 400 new cases every week.

The moment Ebola took over the country, the Liberian health sector had hardly managed to recuperate from the consequences of years of civil war. Poorly funded, over-bordered, and under resourced, with thousands of health care workers kept on for years as volunteers and those with a contract seriously under paid.
During the crisis it became soon clear it were up and foremost the health workers who got hit the hardest and paid the price of the bad working conditions, the inadequate system and the lack of protection. Government and other stakeholders ignored the unions' call for protection, better working conditions and incentives / bonuses to keep health staff at work in such a dangerous environment.

The Liberian Government had no plan to protect her health care providers. In the last ten years not one public health worker was vaccinated against any disease condition and no Occupational Health & Safety Division have been installed at the work places. Ebola did not change that lack of intention.

In all three countries, when confronted with the lack of action of the governments to try and protect the health workers, unions took actions. In Sierra Leone for example, unions called upon the health workers not to treat patients if no protection is available, in an attempt to slow down the death rate amongst health workers.

In Liberia, protests were organised by the two health workers' unions, the National Health Workers' Association of Liberia (NAHWAL) and the National Private Sector Health Workers' Union of Liberia (NPSHWUL). Although officially, NAHWAL, representing health workers in the public sector, is not officially recognised as a union, since the Liberian

government, even after signing the ILO convention on the right to organise, still does not allow public servants to join a union. Although having gone through all required processes and paying Business Registry tax as a Trade Union for two years in a row, NAHWAL has been denied a union certificate. The Ministry of Labour never officially replied to the written request for explication. The denial has big consequences, starting with the denial of the right to social bargaining and the right to collect member fees.

In February 2014, after the government failed to live up to the agreements from prior negotiations, Health workers went on a nationwide strike. The government responded with the engagement of students without licences, who were promised 3 times the normal salaries. Many were not even paid. Twenty two union leaders across the country were pronounced fired without any hearing by the Health Minister of Liberia. Following an intervention by nearly all stakeholders, twenty were called back. Joseph S. Tamba and George Poe Williams, president and Secretary General of NAHWAL, stay without job up till today. Their accounts were put on hold as of May 2015.

After this, more union intimidation followed. Chapter head of Bong County Martha C. Morris, a prominent leader of NAHWAL, was one of the twenty two NAHWAL leaders who were black listed for dismissal. She eventually got recalled but her name was removed from the payroll for eight months. Martha, a dental nurse and department supervisor, advocated for and succeeded in the construction of an Ebola Treatment Unit in Bong County. Under her coordination and strong advocacy, the NAHWAL division in the Bong district grew out to be the association's strong hold. But after she openly questioned the working condition and wages of the staff of the ETU, she was never paid the 8 months of salary the government still owes her.

NAHWAL's River Cess County representative, Borris Grupee, was transferred from Cesto City to an isolated village in order to make it impossible for him to oversee the affairs of NAHWAL in that county. Several other union leaders and active members have been threatened in a similar way across the country.

Also other unions were targeted: the President and Secretary General of the Roberts International Airport Workers Union (RIAWU) were dismissed and the collective bargaining agreement (CBA) signed between RIA management and the workers got suspended.

In October 2014, when Health Workers in demand for hazard pay and protective gears went on strike, government again brought in unemployed people, some not even health professionals. It also threatened to dismiss those who would not report to work. Also this time, the new personnel did not get what it was promised.

Union collaboration in Liberia on Trade Union Rights

Current situation

Luckily for all three Ebola countries, the international community stepped in with money, logistics and human resources. Now, at the end of the emergency period, IPC materials are available. This current level of availability must be maintained at all times in order to avoid future recurrence of massive death amongst health workers and population. Health workers still need training and constant refreshers on Ebola control by WHO and other partners in order to keep them prepared at all times.

Union repression by the Liberian government continues. Health workers' unions have not been included in any consultation by the government and the tactic of dismissal of trade union leaders is intimidating not only workers who have no job security and therefore prefer to keep their under paid jobs in a country where unemployment is not exceptional, many union members become afraid of being identified with trade unions and won't participate in meetings, let alone support actions. This severely weakens the action power of the movement and calls for trade union capacity building and empowerment, and an elaborate campaign to bring the current leadership in Liberia to terms with ILO conventions on the right to organize and trade union rights.

CONGO: UNITE THE UNIONS!

SOLSICO in consultation with the Health Promotion Officer of the WHO in DRC

The Congolese population has no access to a qualitative health system, since the health structures are in an advanced state of disrepair, especially in the provinces. The deliverers of the health services aren't adequately nor continuously trained to strengthen their capacities and enhance their knowledge about the disease.

The last evaluation, held in 2012, ascertained that the health professionals in DRC are working in very bad circumstances, characterised by a growing need of protective equipment, leaving the workers exposed to contaminations and the risk of dying because of the occurrence of diverse epidemics, such as IST/HIV-AIDS and the Ebola Virus Disease.

Because of the isolation of the far away regions, the Ebola virus is less able to spread as it did in the West-African region, and therefore does not seem to attract the same international attention, but it keeps reoccurring and is as deadly and contagious as elsewhere. These last years, DRC experienced several deadly occurrences of the Ebola Virus disease, which led not only to deadly victims amongst the population but also among the health workers that were fighting daily to save others from the virus because of a lack of decent protective equipment. Furthermore, the nurses, especially those working in the provinces North and South Kivu, Orientale and Equateur, where wars repeatedly re-emerge, are often confronted with violence at the work floor. Whilst trying to rescue others, they put their own lives in danger. Moreover, the health professionals are not only not protected themselves, the families of the deceased victims of the virus have never been compensated or taken care of by the state.

The state never ratified ILO convention 149 concerning Employment and Conditions of Work and Life of Nursing Personnel and convention 151 concerning Protection of the Right to Organize and Procedures for Determining Conditions of Employment in the Public Service and the state budget assigned to health does not meet the needs of the activities that are supposed to be organised for the population. DRC is a country with a very high potential for epidemics, while the budget allocated to health is only about 5%. On top of this, the resources attributed to the health facilities are badly managed, if ever they arrive in the facilities itself at all. In these circumstances, the sanitary structures are incapable of offering a universal coverage and protect against health crises such as Ebola and HIV/AIDS.

SOLSICO, Union Solidarity of Congolese Nurses, the Congolese PSI affiliate in the health sector, is tacking up the challenge and participates in the Ebola Response Strategy. A first big challenge is the scattered union landscape in DRC. Only the doctors, who already have a specific statute, are implicated in the elaboration of policy. The Nurses and health workers unions have never been implicated in the decision making process on crisis preparedness, nor in the reform of the Congolese health structures. This causes a lot of frustrations and widens the gap between the different professional categories of the health sector. SOLSICO is now trying to get the different health union around the table for a better collaboration.

But SOLSICO does not restrict its activities to the union environment and has been reaching out to different actors of civil society, in an attempt to create a large network of support for improvements in the health sector, an increase of the health budget, the ratification and implementation of the ILO conventions linked to the Conditions of Work and Life of Health personnel. A network that can take its place in the consultations and decision-making process on the eradication of the Ebola Virus Disease, crisis prevention and general health issues. In preparation of this, it brought a visit to Ghana where it learned from the Ghanaian union HSWU its tips and tricks for the elaboration of fruitful collaborations on union topics and the coordination of joint long term campaigns.

GHANA: UNIONS INVOLVED

In Ghana, 151 cases were tested on Ebola, but luckily none got confirmed. Since the country did get classified as one of the 15 countries with high risk of EVD infection, a National Preparedness and Response plan was developed around 5 thematic areas: Coordination, Surveillance, Case Management, Logistics & Finance/Security, and Social Mobilization & Risk Communication. The plan includes the elaboration of a large coordination structure, the establishment of rapid response teams, communication lines from the community level to the national level, basic materials for rapid response, data collection forms, training on safety procedures for laboratories, Personal Protective Equipment for regional, teaching and some district hospitals, communication and campaigns in media and schools, etc. The plan also provided incentives and support for health workers involved in Ebola in 3 areas: Direct Cash transfers, life insurance and Treatment.

Despite the quite comprehensive plan, there remain challenges in terms of incomplete treatment centres, insufficient trainings at district level, inadequate simulation exercises, and the lack of earmarked funds for the EVD response. The rapid response teams might be trained, but not fully as a team with clear roles and responsibilities and an update of the National Preparedness and Response Plan is needed.

HSWU, the Ghanaian health union followed the developments closely and made the additional demand for financial support for families of health workers who have died of Ebola. This support should consist not only of a lump sum but also of the payment of the deceased health workers' monthly salary until this person would have achieved the age of 60, the compulsory retirement age in Ghana. Also the children of the deceased worker should be taken care of. HSWU introduced child survival benefits so the child's education is assured. This could be done by government scholarships and the establishment of a fund to support the child survival benefits.

But hopefully it will never have to come to this. In order to reduce the risk of cases to a minimum and to prevent any victims amongst health workers, the Ghanaian unions still strive to strengthen the epidemiological surveillance in the country, to train and sensitize the health workers on Ebola and continuously provide information on the matter to the public. So Ghana is able to detect, contain and treat any case that may come up.

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