

In depth interviews of health workers in Sierra Leone report



June 2014

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Abbreviations

ANC – Antenatal Clinic

BeMONC – Basic Emergency Obstetric Neonatal Care

CHO – Community Health Officer

CHW – Community Health Worker

CNO – Chief Nursing Officer

CHC – Community Health Centre

DMO – District Medical Officer

FHCI – Free Health Care Initiative

HRH – Human Resource for Health

HW – Health Worker

IDI - In-depth Interviews

IMCI – Integrated Management of Childhood Illness

M and E – Monitoring and Evaluation

MOHS - Ministry of Health and Sanitation

PBF – Performance based finance

PCMH – Princess Christian Maternity Hospital

PHU – Peripheral Health Unit

RAA – Remote Area Allowance

ReBUILD - **R**esearch for **BUILD**ing Pro-poor Health systems during recovery from political and social conflict

SECHN – State Enrolled Community Health Nurse

SHO – Senior House Officer

SRN – State Registered Nurse

Acknowledgement

This work was carried out as part of ReBUILD research programme (Research for building pro-poor health systems during the recovery from conflict), funded by the UK Department for International Development. Our thanks go to all the health workers who participated and offered us their views and expertise.

Executive summary

Coherent human resource for health (HRH) policies should be designed to address the challenges faced in recruitment and retention of health workers, particularly in developing countries. In Sierra Leone, there are challenges in providing equitable healthcare for all due in part to the current HRH situation, which includes an unequal distribution of the health workforce between urban and rural areas. There is therefore an urgent need for evidence based research that is policy driven and relevant to guide the Ministry of Health and Sanitation (MOHS) to effectively plan, manage and utilise its valuable human resources.

Thus, to document the evolution of incentives for health workers post-conflict and their effects on HRH and the health sector and to derive a recommendation package for retention of rural health workers from a health worker's perception, a qualitative study involving in-depth interviews with health workers was conducted by ReBUILD in 2012-13. 23 public sector health workers of different cadres, working in four regions, were interviewed. The study used a life history approach to explore health workers' experiences over time, including their decision to join the health professional workforce, the choices they made in taking jobs, their satisfiers/dissatisfiers, their experience of conflict, and their perceptions of the effectiveness of different policy measures. These themes were analysed taking gender, urban/rural and cadre of health professional differences into account.

In general, retention challenges in the health sector of Sierra Leone can be attributed to the level of income earned not being in line with the cost of living, non-implementation of HRH incentive policies where they exist, problems with deployment and management of personnel (including political interference in postings, poor relationships with colleagues and the administrative hierarchy in relation to discipline and career management), poor systems for motivation, poor working conditions, limited provision for individual professional capacity development (with regional disparities in urban versus rural) and the lack of an appropriate retention package for rural posted health workers. Financial incentives alone are not enough to motivate health workers in rural areas. Reasons behind poor retention of health workers in rural areas include the lack of accommodation, lack of access to basic amenities for personal and professional use, weak transport infrastructure and irregularities in financial incentive packages.

The study has provided useful policy driven insights into how health workers perceive their professional careers and the incentive environment in Sierra Leone, which can be utilised by policy makers in the development of a long-term HRH development plan for quality service delivery.

Some of the recommendations arising from the study include the following:

1. The recruitment process for health workers in Sierra Leone is too centralised and sometimes causes inordinate delays, allowing local managers no role in staff selection and performance management. This should be addressed as part of the establishment of the new Health Service Commission, whose mandate is to recruit human resource for health (HRH). Decentralisation of the process might also reduce the time which is currently taken to engage new staff, something which causes demotivation and attrition.
2. A full package of measures should be introduced to address the rural/urban divide for health staff. These should go beyond the currently erratic RAA to include: specific tours of duty (e.g.

two years), which are respected; preferential training access for those who are working in rural areas; and provision of housing close to facilities (especially for female staff, for security reasons)

3. Routes into the medical profession for those of low income should be encouraged as it is likely that these staff, especially if mid-level, will more easily be retained in rural areas.
4. The development of a career structure with options for progression in pay and responsibility for CHOs should be developed (e.g. through the Scheme of Service which is currently being developed for Health Workers in Sierra Leone).
5. The PBF scheme should be reformed so that payments are regular (monthly, rather than quarterly), paid on time, and transparent. It was clear that as well as the financial top-up, health workers appreciated getting feedback on their work in the form of an appraisal system, and a way of providing this in a supportive way should be built into the PBF process.
6. The issue of controlling political interference is more delicate but could be addressed through the new Health Service Commission as well as through organisational culture changes of a broader nature.
7. The RAA should be reviewed to establish the additional costs of living and working in rural areas. It is not just a motivation scheme but also needs to cover the extra costs which health workers face. Greater involvement in its design would also ensure that health workers understand how it is meant to operate.

Introduction

ReBUILD is a six year research project funded by the UK Department for International Development (DFID). The ReBUILD research programme focuses on health system development in post-conflict countries, to help governments understand how to make or recreate and sustain fair health systems. Countries included in the study are Sierra Leone, Uganda, Cambodia and Zimbabwe. It aims to understand how to strengthen policy and practice related to health financing and how different health financing strategies affect the poorest households. It also seeks to understand how different innovations in human resource management and opportunities for reallocating roles among health professionals can lead to improved access to health care.

A situational analysis conducted in 2011 in Sierra Leone led to proposals for research being developed in three main areas:

1. Health financing, with a focus on access and payments by poor
2. Health workers incentives and
3. Decentralization and contracting

These studies are being conducted by the ReBUILD Team based at the College of Medicine and Allied Health Sciences (COMAHS), with support from Queen Margaret University in Edinburgh and the Liverpool School of Tropical Medicine. The main goal of the health workers' incentive project is to understand the post-conflict dynamics for health workers and ultimately, how to achieve and maintain incentive environments for them to support access to affordable, appropriate and equitable health services. Researchers conducted in depth interviews with health workers to explore their perceptions on this subject, the findings of which are the focus of this report.

Background to the research

Health worker attraction, retention, distribution and performance are pivotal factors in ensuring that health systems are efficient in providing accessible health service and effective coverage for all. In both developing and developed countries, failure to attract and retain health workers in remote, rural areas has created a geographic imbalance in the health workforce and challenges the aspirations of achieving equal access to health for all. This is an even greater challenge in post-conflict countries, where the health systems and the livelihoods of health workers have been severely disrupted. In addition, the World Health Organisation's (WHO) 'Increasing Access to Health Workers in Remote and Rural Areas, Through Improved Retention' report (WHO, 2010) identified research gaps and highlighted the need for evidence based research to be carried out in low-income countries. Research is needed to fill the dearth of compelling evidence on issues surrounding the maldistribution of the health workforce in rural versus urban areas in the developing world.

Global policy recommendations have been developed by WHO to assist decision-makers seeking to address rural attraction and retention issues. The recommendations cover the four main categories of education, regulation, financial incentives, and personal and professional support (WHO 2010). Improving the attraction and retention of health workers in remote parts of Sierra Leone is essential, especially to ensure that the Free Health Care Initiative (FHCI), introduced in 2010, is sustained at the health care delivery level.

Rationale

Establishing the right incentive environment for health workers in post conflict settings is a significant challenge. The contextual dynamics affecting them are important to understand to enable effective and sustainable policy measures. In post-conflict Sierra Leone, existing ‘incentive packages’ for the retention of health workers are mostly financial, but very little is known about the effectiveness of such packages and their sustainability in the long term (ReBUILD & COMAHS, 2012). The current fragile health system in Sierra Leone can be described as having inadequate human resource for health (HRH), combined with a history of low, irregular remuneration for health professionals. The latter has been addressed in part by a salary uplift in 2010 and the introduction of a performance-based financing (PBF) scheme for facilities and health workers in primary healthcare facilities in 2011. Both of these were linked to the FHCI, which was launched in 2010. A remote area allowance (RAA) scheme was also introduced in 2011. To date, no study has focused on the impact of decisions made, or not made, in the post-conflict period on the attraction, retention, distribution and performance of health workers, and thus ultimately the performance of the sector. As one of the tools to address this issue, a participatory approach was taken to understand health workers’ experiences over the post-conflict period and their policy recommendations.

The research programme developed a conceptual framework, which aims to investigate the linkages between contextual factors, personal attributes and policies, and to understand how these have influenced HRH outcomes in the post-conflict period. The life history/in depth interview method was chosen as one component because it allows for an exploration of the personal perspective of the health workers. If successful, it can illuminate how personal factors interlink with a changing context and a dynamic policy environment, how these are perceived at the service delivery level, and how they change over time.

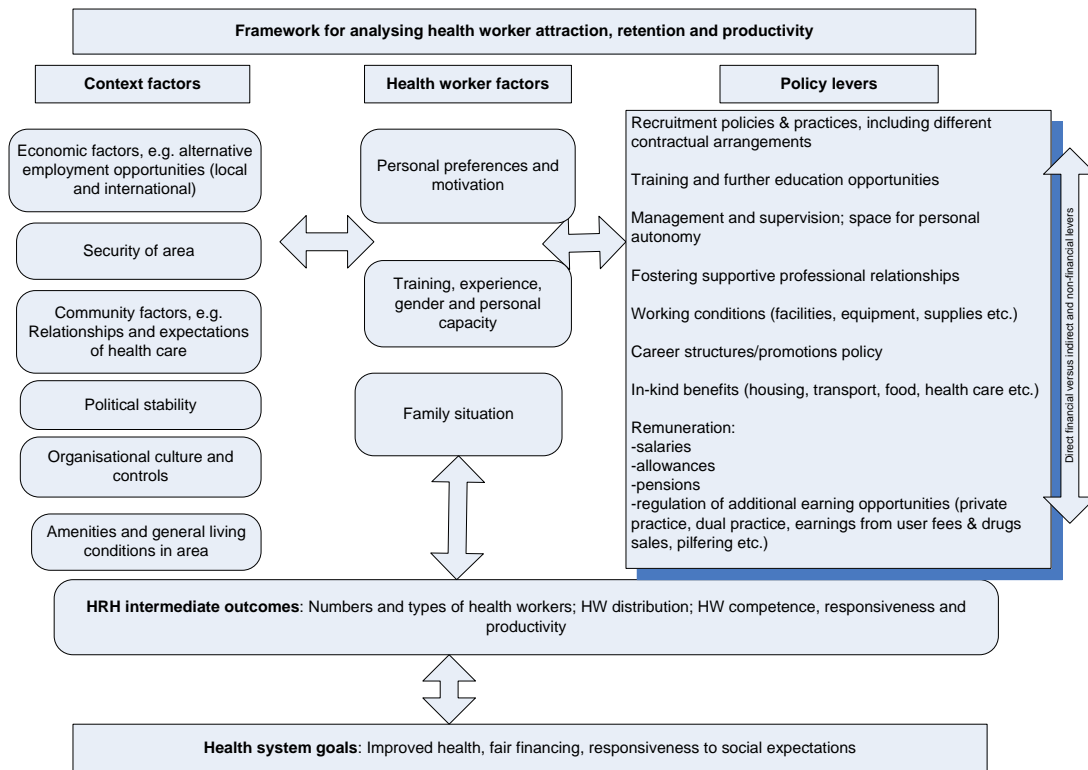


Figure 1 Conceptual framework, HW incentive research

Objectives of the sub-study

The objectives of this sub-study were:

1. To explore the overall perceptions and experiences of health workers before, during and after conflict
2. To identify health workers' motivating and demotivating factors and coping mechanisms
3. To understand health workers' views on the post-conflict evolution of incentives for health workers and factors which would encourage or discourage them from staying in post and being productive in remote areas
4. To deduce recommendations for effective approaches to retain health workers in hard-to-reach areas to support access to rational and equitable health services

This sub-study was complemented by other research tools, including a health worker survey, routine HR data analysis, stakeholder mapping, document review and key informant interviews. As well as providing the basis for recommendations for Sierra Leone, the findings will also feed into comparative cross-country analysis.

Research methods

In 2013, the ReBUILD Sierra Leone team conducted in depth interviews among different cadres of health worker in the four chosen study sites. The study sites were spread across rural and urban areas and included the four regions of Sierra Leone. The aim of the interviews was to understand

health workers' experiences and career decisions and to investigate preferences for potential attraction and retention strategies for postings in the country's rural and remote areas.

Tool development

Tools were developed using a participatory approach between ReBUILD team members from Sierra Leone and the UK. A generic topic guide was produced by the UK Lead Researcher and was then adapted by the local team during a pilot and training exercise. It adopted a mainly chronological order for the sequencing of the questions. It looked first at the background of the health worker in terms of education and explored further the factors that influenced their career choices

The topic guide (see Annex for tools) was designed to explore the following subjects:

- How and why they became health workers
- Their career path since they became health workers, and what influenced it during and after the conflict
- Their overall perception of their career in terms of motivating and demotivating factors before, during and after the conflict
- Challenges they face in their job and how they cope with them before, during and after the conflict
- Their career aspirations
- Their knowledge and perceptions of incentive policies during and after the conflict
- Recommendation for an effective retaining package for health workers in rural areas

Participants were requested to draw their career life lines while the interviewer simultaneously probed for more understanding and information at given points/events along the participant's career life-line. However, the majority of the timelines were not completed. .

Study design

This was a qualitative study involving in-depth interviews with public health workers, reflecting on their careers.

Study sites

The study sites chosen were representative of the different regions of Sierra Leone, including rural and urban areas and areas of varied socioeconomic status. The study sites were:

- Western Area District - including urban and rural areas
- Kenema District (Eastern Province)
- Bonthe District (Southern Province) – hard to reach, rural area
- Koinadugu District (Northern Province) - hard to reach, rural area

Study setting and population

In depth interviews were conducted with health workers in health care facilities. A total of 23 in depth interviews were conducted and a summary of the interview locations is given in table 1. Our target number of interviews was not met in the provincial towns of Kenema and Bonthe, due to staff not being available during the visit to the health facilities. All of the respondents worked at

government health facilities. The higher number in Western Area reflects the concentration of facilities in this region.

Table 1: Number of in depth interviews per district

District	Intended number of interviews	Actual number of interviews conducted
Western Area	11	11
Koinadugu (North)	5	5
Kenema (East)	5	4
Bonthe (South)	5	3
Total	26	23

Participants that met the inclusion criteria of having worked in the health sector since 2000 were selected. This criteria was set to capture the evolutionary theme for the study and understand how their lives have changed since the war, a subject that could be discussed only by health workers with longer experiences in the health sector.

Table 2: Gender of respondents

Gender	Number of respondents
Females	12
Males	11
Total	23

It was intended that three health workers (1 Doctor, 1 Nurse and 1 Midwife) would be randomly selected from each district hospital of the study sites, and three each from the main referral hospitals in the Western Area (i.e., Connaught, Princess Christian Maternity Hospital (PCMH) and Ola During Children's hospital). In addition two community health workers (CHOs) from in each study district were to be interviewed. Instead, a mixture of hospital and community health workers was selected from the designated study sites. In the Western Area, respondents were selected from the main referral hospitals targeting at least one doctor and either one nurse or one midwife (depending on the type of hospital e.g. exclusively maternity, children's or other) from each hospital as these are the targeted groups for retention. In addition, CHOs from each study district were interviewed. The selection of the CHO in the provinces was based on how remote/difficult to reach facility was and the catchment population. In the Western Area, one CHO each was selected from a rural community health centre (CHC) and an urban CHC.

Table 3: Cadre of health workers included in the study

Cadre of health professional	Intended number of participants	Actual number of respondents
Community Health Workers/Community Health Officers	8	8
Nurses	6	5
Midwives	6	7
Medical Officers	6	3

Due to the long length of service as a selection criterion for health workers to be included in this study, the majority of the study population were in the medium to high level cadre bracket. This is because doctors and nurses or midwives who have worked for some time in the sector are more likely to have reached more senior positions and be based in tertiary health facilities.

Table 4: Distribution of health workers by type of health facility

Type of health facility	Number of respondents
Primary Health care facility	7
Secondary health care facility	4
Tertiary healthcare facility	12

The different cadres of health professionals mentioned in this study and a brief description of their job role is given in table 5. All low level cadres of health professionals (grades 4 and below) have the additional duty of record keeping.

Data collection

Data was collected using an open topic guide. The interviews were recorded, after gaining informed consent from the participants, and were conducted in a location selected by the respondent that they deemed as private and comfortable. High level health workers in tertiary hospitals had access to private and quiet office space that was utilised during the interviews. This was not the case for other cadres of health worker, particularly those working in community health centres. In some cases due to lack of available space in the health facilities, office space that was accessed frequently by other health workers in the health facilities was used to conduct the interviews which meant interruptions during the recordings. Fieldwork was undertaken in March 2013 in the provincial study sites and in October 2013 in the Western Area. The provincial interviews were conducted by one researcher and the Western Area interviews by another.

Table 5: Summary of roles of the some of the main cadres of health professionals in Sierra Leone

Cadre of health professional	Grade	Job description
Maternal and Child Aides (MCH aides)	2	Conducts safe motherhood services including ANC, deliveries, postnatal care, family planning and immunisation and participates in community outreach services. Mostly posted at MCH posts but also found in some Community Health Centres (CHC)
State enrolled community health nurse (SECHN)	4	Conducts routine ward functions, outreach services (e.g. immunisation, health education) and assists in the provision of safe motherhood services. Mostly posted in CHCs and in some tertiary hospitals
State registered nurse (SRN)	6	Assists in ward administration and management including ward functions. Mostly found in hospitals and some CHCs in the Western Area
Staff Midwife	6	Conducts maternity services at PHU and community level, manages basic obstetric and neonatal emergencies and is involved in community sensitisation on basic obstetric and neonatal care and other health related issues. SRN qualified midwives are mostly found in hospitals and SECHNs with midwifery qualifications are found in CHCs and hospitals
Public Health Sister/District health sister	7	Organises, plans and implements MCH/extended programme on immunisation (EPI) activities at the PHU level and monitors and evaluates health programmes and activities at the district and PHU level. In addition they participate in health reviews and collaborate with other district health management teams (DHMTs) and other international and national non-government organisations (NGOs) on health activities in the district. Mostly found working within the DHMTs and National Health programs e.g. Extended immunization programme (EPI)
Matron	8	Responsible for the management and supervision of the nursing/midwifery staff and other support staff. In addition, assists with the preparation of the annual work plan and budget and in the formulation of protocol and guideline in their area of operation. They also assist in the preparation of annual requisitions for the hospital and in the preparation of the human resource for health (HRH) plan for the health facility. Found working in tertiary hospitals
Chief Nursing officer (CNO)	12	Involved in the development of National Health Policy and Strategic Plan and Directorate Strategic Plan. Other duties include the development and implementation of a nursing policy and action plan together with supervision, monitoring and evaluation of nursing programmes at national, regional and local level. Found working at the MOHS
Community Health Officer (CHO)	6	In charge of primary health care units (PHUs), including managing drug stock, diagnosing and providing treatment for common diseases and referring medical, surgical and obstetrics emergencies appropriately. Mostly found working in CHOs and some regional hospitals
Senior Community Officer (CHO in charge)	7	In addition to the above, serves as a zonal supervisor of other CHOs at the PHU level and/or at district level as assigned by the District Medical Officer (DMO).
Medical Officer/Senior Medical Officer	10	Serves as a medical officer-in-charge in a district hospital who sanctions and orders the admission of patients into the hospital and undertakes patient care and treatment. In addition, they deal with referral cases coming from the PHUs. Found in hospitals
Specialist/ Senior Specialist	13	Carries out high-level procedures that require specialised skills and offer training to other medical and nursing staff and usually also serve as programme, unit or directorate heads. Found in hospitals

Analysis of transcripts

The data was analysed using the thematic framework approach. The analysis framework involves the following stages: transcribing the interviews, familiarisation of the transcripts and the audio recordings, producing a coding framework, coding and identifying key themes from individual transcripts, merging themes, searching for key findings under each theme, comparing and finding associations, and providing explanations for the findings.

Interviews were transcribed verbatim for thematic analysis, which was carried out by one of the researchers. Transcripts were read several times to get an overall picture and then recurring themes were identified. A coding framework was generated and agreed upon between team members in Sierra Leone, Uganda and the UK. The codes were defined through the use of constant comparison within and between codes to ensure that they accurately reflected the material. Correlations were then identified between the different themes before being grouped into the broader overall themes. The coding framework went through a number of draft phases as emerging themes that epitomised the central themes were identified and incorporated into the original framework to develop a final coding framework. Individual transcripts were then coded using Word.

Secondly, the interviews were analyzed using the thematic coding, by organizing excerpts from each transcript within a template in Excel. Finally, themes were charted and cross-tabled to help data comparison, highlighting a pattern of relations within the responses to allow interpretation. Each individual theme was then summarised and findings were then synthesised across the main themes, noting patterns and gender differences. The other members of the team provided feedback on the initial results of the analysis and on the draft of the report.

Research ethics

Ethical approval was obtained from the Sierra Leone Scientific and Ethics Committee and the Liverpool School of Tropical Medicine prior to the commencement of the study. Informed consent was sought from the participants, assuring of confidentiality and anonymity of the information collected. There are ethical issues with regards reporting on interviews done with specific respondents who can be easily identified, e.g. where there is only one doctor per district or one monitoring and evaluation officer per district. To address this, findings were reported using codes without names or any details that would enable individuals to be easily identified.

Research limitations

As stated above, in some of the study sites, particularly in the provinces, the intended numbers and cadres of health workers was not met by this project. One major constraint was that high level cadres of health professionals, especially doctors, are always very busy so finding the opportunity to interview them was difficult. In one case the intended high level cadre respondent was unwilling to participate, as they were in fear of devolving sensitive information that might result in termination of their employment, despite the explained confidentiality of the study. Another limitation was the availability of the staff at the health facilities at the time the interviews were taking place. Researchers were left with the choice of improvising by interviewing the available health workers as

returning back to the health facilities was not feasible. This resulted in slight discrepancies in the intended cadre of health workers included in the study, but not such as to affect the value of the views expressed.

Research findings

1. Decision to join the medical profession

A number of the respondents started their careers in other professions before making the decision to join the health sector. Teaching was the main profession that was used as a stepping stone career wise.

‘I took teaching as a spring field really,...[....].....I thought from teaching, from the classroom I can do anything, I can be a lawyer, I can be a medical doctor, I can be any other thing’ (Male, Koinadugu, IDI-12)

In one case the respondent began their career in the environmental health sector, working with health professionals, and his admiration for the health profession motivated him to train to become a health worker.

‘..... right as a water and sanitation technician .[...] right there I started to admire medical personnel [...] and having a background in science.....(Male, Koinadugu, IDI-12)

The factors influencing respondents to join the profession were grouped under personal motivation or calling, the influence of significant others, educational history, social and professional respect for health workers, and financial factors. Similar numbers of respondents reported each of these factors. However personal motivation, influential individuals, social and professional respect for the profession, and educational prerequisite were the most reported influential factors in making health workers want to join the profession. These were followed closely by financial constraints.

Personal motivation

Personal reasons were mainly due to being intrigued and interested by the profession and wanting to explore ways of helping the health care delivery system. Wanting to serve the community by caring and saving people’s lives due to having a caring (and often religious) nature sometimes played a role here.

‘During my primary school days at Rotifunk, there was a hospital managed by the Chinese by then. Whilst we were there most people were going to us and I used to take them to the hospital. During that era I came to realise that serving people through that way appealed to me.’ (Male, Bonthe, IDI-2).

‘I came from school directly to nursing because nursing was my career...[...].....I had passion for people so I decided to be a nurse because I wanted to save humanity and since I am a Christian I thought this way. Because the healing ministry was one of the focus when our Lord and Jesus Christ was on earth so ...[...].....that was my focus to save humanity and to help people’ (Female, Koinadugu, IDI-9)

'I chose nursing as a career, so that I can help especially my family. Looking at the area I came from, medical facilities in those areas is a bit poor, for instance from my village to where we have the health centre is over ten miles' **(Female, Bonthe, IDI-1)**

Influential individuals

Some respondents were influenced by family members or where exposed to the health profession from an early age by having a family member who was a health worker. Of the health workers interviewed, those who were influenced into joining the health sector by family members were predominately female.

'My father [.....] well I think his friend was related to the then principal of the school [.....] so he encouraged him that one of the [.....] should do nursing and I decided to offer myself yeah' **(Female, Western Area, IDI-13)**

'..... My Mother too wanted me to do nursing [.....]....She made all the arrangements that I should do nursing because she had wanted to do it but she did not do it.. [.....]...that's what made me to do it...[...]'and then with the great help of my uncle he decided that I should be in the nursing profession **(Female, Western Area, IDI-15)**

Social and professional respect

Another important factor was how society held health workers in high regard, the dress code of the nurses and the way in which they presented themselves. Respect for the medical profession in society and admiration of health professional mannerisms in terms of the way they walked, they way they talked, and the uniform was very appealing to some. The work ethic of health professionals also fuelled the aspiration of some health workers to join the medical field.

'From the way I saw how the nurses were all well dressed at that time, the doctors were working efficiently.....' **(Female, Koinadugu, IDI-9)**

'I loved it. When I was younger I used to admire the young nurses in our chieftdom headquarter town, the way they dress, the way they walk, they way they talk, so I said if I could be a nurse it will be better for me.' **(Female, Koinadugu, IDI-8)**

'.....right there I started to admire medical personnels.....' **(Male, Koinadugu, IDI-11)**

Subjects taken at secondary level

Another factor that influenced the decision to become a health worker was the subjects studied at O Level in secondary school. In general having done science subjects at O Level predisposed individuals to join the medical profession.

'I studied the sciences; I thought that was a very good opportunity for me to do so, that is how I came into health. I came to that school and upon my graduation I gain acceptance into the Ministry' **(Male Kenema, IDI-5)**

Financial constraints or crisis

Financial constraints were also mentioned as a factor, for example, not being able to afford the tuition fees and therefore opting for the tuition free paramedical school. A crisis in the family and the loss of a family head could also have been the trigger.

‘Because I couldn’t get the support to go to university for further studies I found out that there was a programme in the paramedical school which train middle level cadre health providers; and I opted for that I decided to go into do that since I studied the sciences. I thought that was a very good opportunity for me to do so that is how I came into health’ (Male, Kenema, IDI-5)

....from there nursing was not my, my career [.....] but because of the death of my father by then [.....]....yeah one of my uncles just came up when we were having a family meeting that I should enrol to become a nurse. So let me say I the remaining five years I was I was doing [.....] and then doing some other little course because nursing was not my career my main career was I wanted to become an [.....] but because of the death of my father (Female, Western Area, IDI-15)

‘So when I reach form 5, I said ok if I sit my O Level, I will like to go to the university. But my father died and my mum didn’t have much, so he [referring to uncle] was like advising ‘Why can’t you do nursing instead of going to the university because definitely you cannot afford it.’ So I decided that since it has been my number one area of admiration I think I will continue with that one and that’s how I got interest in this kind of career I am doing now’.(Female, Koinadugu, IDI-8)

‘....but ehmm financially that was not possible, the support I needed was not there and paramedical school was offering cost free education at that moment. So I had to try my luck and fortunately for me immediately I applied the very year I was admitted into the school’ (Male, Kenema, IDI-4)

‘Because I couldn’t get the support to go to university for further studies I found out that there was a programme in the paramedical school which train middle level cadre health providers...[.....]....Initially, actually I want to go to university for a degree program but I had challenges, financial challenges , I did not have somebody to support me so I came to know about paramedical school that once you are qualified and you gain entrance there you are on automatic scholarship. So I opted to go in for that even though that was not my initial choice but because of those circumstances, I decided to go in for that training’. (Male Senior, Kenema, IDI-5)

2. Initial Training

As discussed in the ‘decision to join the medical profession’ section above, taking scientific subjects at the end of secondary school was a prerequisite for initial training to become a health professional. A number of the respondents started off in the teaching profession, presumably as a means to survive, before making the decision to train to become a health professional. Table 5 below shows the distribution of initial training locations.

Table 6: Distribution of initial training location showing ownership

Location of initial training	Number of respondents	Ownership
National School of Nursing – Freetown	13	Public
Paramedical School – Bo	6	Public

Njala University – Njala	1	Public
Fourah Bay College – Freetown	2	Public
Abroad	2	n/a

Location of initial training

The majority of the respondents (91%) from the various cadres were initially trained in Sierra Leone at either the National School of Nursing, Paramedical school, Njala University or Fourah Bay College. A small number of the respondents trained abroad; in one case the respondent opted to study abroad as at that time there wasn't an established school in Sierra Leone for the state registered course in nursing; a second respondent opted to study abroad upon securing an international scholarship and for the wider experience.

'....to be honest with you I would have probably left because at that time there was this fever about just going abroad,[...]... as I said going abroad with some advantages, including people think things are better there than over here....[...].....but I would have probably and that's being honest with you, left yes. At least the excitement of being in the air flying' (Male, Western Area, IDI-17)

'Well there was not an established school in Sierra Leone then for SRN' (Female, Western Area, IDI-23)

Length of initial training

Length of original training ranged from 2.5 years to 6 years, the latter being for training to become a medical doctor. In general the training lasted for 3 years for most of the respondents (with paramedical school having an additional year for post-basic training), but in some cases the training was extended due to the war. In one case, the students were displaced from the school campus as a result of the war.

'Because of the war we stayed longer and graduated 19...I meant 2000, the year 2000.' (Male, Bonthe, IDI-3)

'... right from thenceforth I gained admittance in July 1991 till the war but breakout in '93 and we left the compound' (Male, Koinadugu, IDI-12)

'I went through my training for 4 years because of the rebel incursion by then .[....].. although the SRN course should be for 3 years but I did my own for 4 years because of the interruption of the rebel war by then'(Female, Western Area, IDI-15)

Source of funding

The general consensus was that admission into the National School of Nursing in the pre=conflict period was tuition free, with the students getting financial support from the Government for accommodation and food. Post-conflict, this was not the case however.

'.... the government paid for me and then they were giving us stipend..[....]...yes you are accommodated in the school for free of charge [....]you don't have to pay, they feed you three times a day you have breakfast, lunch and then dinner.[...]..and then at the end of the month we are entitled for stipend'(Female, Western Area, IDI-15)

Paramedical school was also tuition free, which influenced a number of the respondents to opt for it. One respondent initially wanted to study medicine (which was not free) but because of lack of funds decided to go to paramedical school.

'First of all upon my graduation at high school, I wanted to become a medical doctor, I went to COMAHS, I bought the form, I was called for interview but didn't have the money to pay and no family support. So I came back to my village, after 4, 5 months I went back to Bo and I decided to go and do the paramedical course which was I could say free, it's scholarship like' (Male, Koinadugu, IDI-11)

It was also implied that pre-conflict, the process of securing an international scholarship was transparent, as one respondent was awarded this scholarship without any outside influence, political or otherwise:

'...yes so I looked into it because I wasn't sure I was going to get the scholarship because I didn't know who; in those days as now we used to think that we only would get a scholarship if you knew the bigwigs; I was proven wrong. I came and I didn't know anyone, I didn't go to anybody and I was given the scholarship and I was shocked. I didn't even know, it was over a week later after constant announcements over days and days that some friends had and told me you have been awarded the scholarship to go to Egypt' (Male, Western Area, IDI-17)

Experience of initial training

In general the experience of the initial training for the majority of the health workers was positive. Respondents emphasised the adequate training and practical sessions that equipped them with the required skills to succeed in their career. It also provided them with an underlying sense of accomplishment, being able to fulfil the dream of training to become a health worker. This often followed the initial daunting feeling of leaving home for the first time and staying in hostels. The course content, teaching methods, and financial and housing support from the Government were all satisfying factors that were conducive to learning. This motivated the trainees to succeed and provided a training environment that produced health workers whose qualifications were deemed suitable at home and overseas.

'...well for our own standard by then I think it was up to standard because I know majority of my colleague that we trained together that particular year that we came out as an SRN majority have travelled [...]..to the United States and even UK and they are doing perfectly well with that particular qualification.[...]..so I think the standard of education was up to standard.[...]..... because everything was provided for us, it's all just up to you the student to perform perfectly well because if they government has done virtually everything for you it all depends on the output' (Female, Western Area, IDI-15)

'.. the training experience was good 'cause during that time we were actually encouraged as students and we were given stipend at the end of every month [...].. which can keep us unto the end of another month...[...].... the classroom was very conducive [...]....hostel was very conducive (Male, Western Area, IDI-18)

A dissatisfying factor in the overall training experience was the conflict that extended the training period. Another respondent also experienced the challenge of adapting to her new surroundings,

and felt demotivated by the attitude of her tutors. However, she was able to motivate herself to continue.

'In 1996 the civil war in the country and the disorganization of things in the country at that moment, we had to wait until in 1998 when I was posted for what we call something like housemanship or so to under study someone' (Male, Kenema, IDI-4)

'.....well for a start I thought I had found myself in the wrong place because when we started...[...].... you met with strange people who you have never met before that was difficult to get close to some of them. And then you had tutors who will always say "You are stupid, you are noisy....."and then I started saying "What sort of a place have I come to? I wish I had not come here". But then I made up my mind because I was there already....[...]....and I want the job...[...].... I'll continue to pray that I will ...[....].....stay and that I did for the 3 years that I spent in this school; because that was my first time I left my home to stay somewhere else, yes because we had to stay in the hostel' (Female, Western Area, IDI-14)

3. Subsequent training/up-grading

A number of the respondents proceeded on to subsequent training or upgrading programs, both locally and internationally. We look here at their motivation for training, where it was done, how it was funded, and their experiences of the subsequent training. In all cases the training acquired was relevant to their day to day roles within the health care delivery system.

Reasons for subsequent training

Career progression, in terms of moving up the career ladder, was one of the main reasons for acquiring subsequent training. Changing career focus within the health field was also reported as another reason for subsequent training amongst the respondents. Examples of this includes moving from bed side nursing or curative side to the preventive side after acquiring public health training and taking on leadership roles within the primary health care sector. It is clear from a number of respondents that training and experience in preventive and public health is an important pre-condition for promotion and acquiring more responsibility in public service. Doctors tended to specialise, while midwives progressed on to do the midwifery training after acquiring the SRN status, needed for them to work as midwives. In one case, a nurse opted for further training to acquire more knowledge, putting her in a better position to transition into becoming a lecturer in the future.

'After that, in 1990 I decide to improve myself so I went for Senior Registered Nurse (SRN). [...]...it's just a continuation....[...]..as I wanted to improve myself.[....].It was just a continuation, but mind you each time you took a step there must be a difference' (Female, Bonthe, IDI-1)

'....well our own criteria here, if you want to move up the ladder at least you cannot just stop at just SRN you have to do your midwifery and from that particular point you can be promoted..[...].yeah but I mean not because of the promotion per se but I have passion for midwifery so I decided to go for it..[...].Because nursing is growing you can't be satisfied in one position at least you have to equip yourself, .[...].I think I have rendered my service a lot in terms of bed nursing.[....]. I mean when switching to public health you do the preventive aspect.[....]. than more curative .[....]..so I decided to move to that area at least to get some preventive knowledge because if you do public health you be virtually in the field all the time to say exactly what is happening down at any community and what

would be a preventive measure in terms of disease outbreak or any other condition out there...[.]...so I decided to move because I have got a lot in terms of bed nursing' (**Female, Western Area, IDI-15**)

'..... to improve yourself...[.]...and to move from the curative side of things to the preventive side of things.[...] and to for erm career progression really with the hope that you would soon be overseeing community health centres' (**Female, Western Area, IDI-20**)

In one case, a male respondent who had initially trained to become a nurse felt he was in a female-dominated profession and so trained further to become a CHO. When the researcher asked the respondent how he felt working in a female-dominated profession, his response was:

'well that was why I decided ...[....].... there is another institution opened now called the paramedical school where you can be trained as a community health officer. So I decided to went to paramedical school' (**Male, Western Area, IDI-21**)

Experience of subsequent training

In general, specialist courses (e.g. SECHN to SRN, SRN to midwifery, doctors specialising) were long term (2 - 6 years) and the short professional courses/workshops lasted for 2 - 12 weeks. The conflict had an effect on subsequent training as with initial training, resulting in longer training periods and tutors migrating to avoid the conflict.

'But it was unfortunate for us it was during the war.[....] This was the time the war was very close or even in Freetown now, so some people went out (i.e. left the country) even our tutors were not around. We even lost a tutor of ours...'. (**Female Bonthe, IDI-1**)

One issue mentioned in relation to subsequent training was financial difficulties, as the Government stipend was delayed in some cases. Female respondents also had the additional burden of juggling looking after a home, studying full time and dealing with personal problems.

'.....lot of other constraints were there.....[....] the first thing was it was the Ministry of Health and Sanitation had an obligation and responsibility to take care of that school; and then at that time students were given stipends, this stipend was there to assist students to pursue their course and it will surprise you that you will be there for 6-7 months, a single stipend will not be available ' (**Male, Koinadugu, IDI-12**)

'..it was challenging yes because I was married by then....[....].... when I did my SRN I was not married I was staying with my parents. When the midwifery was challenging because I have to work plus I have to cook I have to study it was very hectic for me' (**Female, Western Area, IDI-15**)

Those who trained outside of Africa experienced cultural differences and language barriers. One of the respondents who had trained overseas felt regret at the cost involved, as in his opinion it would have been cheaper to train in Africa.

'.... well it was challenging because I had mistakenly acted foolishly, ..[...] because if I had used that money to go to West Africa, I say Nigeria to do the fellowship in West Africa college, that money would have been enough to have lasted throughout my training period but there, the cost was so

astronomical that the money got finished and the guy had to be come into help and I had to take come odd jobs and that to stay on.’ (Male, Western Area, IDI-17)

Location of subsequent training

Subsequent training, e.g. short professional courses, was largely done in Africa but outside of Sierra Leone, compared to the initial training that was done mostly in-country. Doctors opted to specialise out of country which highlights the need for accreditation of local institutions to lead in facilitating professional or subsequent training courses locally:

‘.....so all of these people now we are putting at the forefront they take care of wards, they take care of children without even our supervision. These are house officers, we cannot supervise them because there is only two of us so when they come maybe they are with us one or two week and then they go out and then they go and take care of cases. ...[.....].....but now the thing is we don’t we don’t even have the consultants who will help us train; I mean there are not enough so that’s why the ministry told us they have been sending some of our doctors to the sub-region some have gone to Kenya some are in Nigeria and some are in Ghana’ (Male, Western Area, IDI-19)

The study also revealed a slight disparity in opportunities for training outside Africa. Training outside the Africa region was limited to higher cadre staff (e.g. medical officers) upon acquisition of an international scholarship, and training opportunities within Africa were available to middle level cadre of staff (e.g. matrons and senior CHOs).

‘....Russia up till 1994 June , then 1995/96 same university, Diploma in General Medicine.[....] recently at 2011 I went to China under this hospital management business.[...] we saw some improvement again in the knowledge of managing hospitals and so on and so forth that’s another good one’ (Male, Kenema, IDI-6)

‘...I had the opportunity to go to Botswana for a training in paediatric HIV care.[....] 2012 August to be precise I also had to opportunity to go to Nigeria’ (Male, Kenema, IDI-5)

‘.....I was privileged to attend a course in management in Ghana so when I came back I was really enthusiastic because it was really motivation, so this is what I am saying that in order to motivate us in order to do our work especially for those of us working in the provinces in the remote areas, when these training opportunities come they should pay more attention to us in the remote area’ (Female, Koinadagu, IDI-10)

Table 7: Subsequent training location

Health professional cadre	Location of subsequent training	Training undertaken
District Health Sister 1	Fourah Bay College	Postgraduate studies
	Midwifery School at PCMH Hospital	Midwifery training
CHO	Paramedical School – Bo	Diploma course
CHO	Njala University – Sierra Leone	Postgraduate studies
Midwife	Midwifery School at PCMH Hospital	Midwifery training
Midwife	Midwifery School at PCMH Hospital	Midwifery training
Matron (Midwife)	Midwifery School at PCMH Hospital Ghana	Midwifery training and Short course
Matron (Senior Midwife)	Midwifery School at PCMH Hospital	Midwifery training and

	Ghana	Short course
Senior CHO and M & E officer	Botswana	Short Course
Matron	Ghana	Short course
Matron	Ghana	Short course
Nurse (Matron)	Nigeria	Postgraduate studies
Matron (midwife)	Ghana	Short professional course
Medical Doctor	China	Degree programme
Surgeon Specialist	Russia	Degree programme
Medical Doctor	United Kingdom	Specialise
	Nigeria	Residency programme

Sources of funding

Sources of funding to undertake further studies included donor agencies, government scholarships via bilateral country agreements and philanthropic sources.

'The training itself was very good because by then [i.e in the early 90] the European Union was paying 75% for the students' (Male, Western Area, IDI-21)

One issue that emerged from one of the interviews was the lack of funding and encouragement to facilitate doctors to specialise in areas other than public health, which translates into a lack of specialist doctors in the hospitals. Recalling his experience in the late 1980s, the respondent was not encouraged to specialise in his chosen field as the MoHS did not consider this as a priority and only made provision for doctors to specialise in public health.

'I wanted to go and specialise, but Government, the Ministry would not give me a scholarship. They said that neurology which I said I wanted to specialise in, was not a priority, that surgery in fact was not a priority. If I wanted to go and do an MPH in public health I was welcome' (Male, Western Area, IDI-17)

Subsequent training for SRNs going on to do midwifery was free of cost.

Benefits from training, once in the workplace

One respondent was disappointed that the professional environment to implement his acquired skills and knowledge was missing.

'..... I had interest in maternal and child health so there was a programme on paediatric HIV care...[...]. that I opted to participate in...[....]....I had the opportunity to go to Botswana for a training in paediatric HIV care..[....]....we did that training with the hope that because promises were made that centres are going to be establish at regional levels.....[.....].....they will establish centres that will be caring for children with HIV; but ever since we returned I still stayed in that PHU we have made follow ups at national level but nothing was done about that so that whole programme just went silent' (Male, Kenema, IDI-5)

In this same case, the respondent was dissatisfied with the qualification gained at the end of his initial training to become a CHO, feeling that it impeded his career progression. He then enrolled on a diploma course, in the hope that this would increase his chances of progressing along the career ladder. Another CHO expressed the same disappointment about the structure of (or lack of it) their scheme of service upon completion of training.

'After I left, I did the CHO training [...]. as an opportunity for me to grow in the career.[...].... The course we did was equivalent to a degree course. Looking at the course curriculum all the training that we went through was an equivalent to a degree course but we were just given a mere certificate that was not even recognize by our university in this country. So that was very frustrating and in fact that was a point in my life that I regretted going in for that training. I thought initially I had wasted my time for nothing, but because there was no other way out and that was the certificate I used to get employment in to this ministry, so we waited until that time, that opportunity came so I decided to go in and I still want to back for further studies in the same field' (Male, Kenema, IDI-5)

'Well to my greatest disappointment, paramedical and the way it started and the way it should be is not nice, because it's like we were trained to be isolated, we are not even licenced to work in this country, we have no scheme of service, you know, we've tried to work on that several years up to now, there is no avail. It's now that we have got our chief CHO. But there is a gradual movement now, there is progress. Otherwise we are, some of us have been discouraged in working as CHO'.(Male, Western Area, IDI-21)

The opposite was experienced by another CHO wherein the skills and training acquired during short professional courses were fully implemented in the district.

'Well as far as I look at things, there have been some in-service training like the BEmOC,[Basic Emergency Obstetric Care] live saving skills.[...]...participating in the trainings like the HIV and AIDs and counselling, I have served as the chief of counsellor for the HIV and AIDS and I have also been trained in child survival programs like IMCI that were implemented fully in the district.' (Male, Koinadugu, IDI-11)

4. Career trajectory

Upon completion of their training, health workers were posted to their job stations, a process that seemed to be controlled entirely by the MOHS, and was usually followed by a health worker acquiring subsequent training. The number of postings for each health worker ranged from 2 to 10, with an overall average length of service of 19 years (range of 6 – 35 years).

With regards to the postings, there seems to be a general trend of increased responsibility from one posting to the next. Postings were based on speciality, especially in the higher cadres, with doctors being recommended to be posted to a dilapidated hospital to help improve the quality of service delivery being offered in the health facilities. There was also a trend of health workers who had gained experienced working in Freetown being posted to the provinces to take up leadership positions. However it was not captured during the interviews whether this salary scale was in line with the level of responsibility.

However, some postings were reluctantly accepted as in one case; the respondent was given the option to either accept the posting or face redundancy. In another incident the same respondent had his posting changed due to political interference.

'I came back they couldn't sponsor me to go back instead they started threatening me to resume work or I'll be sacked, yes, so I dared them to sack me so I walked away for a while in '91 [...] initially

I was posted as the Medical Superintendent but politics you know politics, the posting was changed even without informing me'. (Male, Western Area, IDI-17)

In general higher level cadres tend to serve as administrators, which was welcomed by the health workers as it helped their professional development. On the other hand, it highlights the limited staff number or lack of staff with the required skills and experience.

'A lot of roles...[...].I will give you some examples like now we don't have anybody per se attached directly to the tuberculosis ward so sometimes you have to chip in as a physician, [...].I am both an administrator and a surgeon, a consultant you name it. So if I have my junior colleagues there stuck up with something they will run up to me and I'm always willing...[...]. then at the same time I'm a paediatrician....[...]. and at the same time you have to go round talk to councils. Sometimes you even have to work to the level of a politician because as a state man you have to make sure you are able to impact or pass what you need for your hospital to function properly and so on and so forth' (Male, Kenema, IDI-6)

A senior CHO accepted a job offer to work as an M&E officer as he felt the professional development within this cadre, i.e., CHOs, was not progressive enough and felt that taking on this additional role would allow him to equip himself with the required skills for professional development.

'So when I was called upon to come to the DHMT..[.....].I really had some interest in the clinical practice but because I had been there all these years, there has been no, I mean development, I had no opportunity to go for further studies in that area, so I thought this was going to be an opportunity to improve myself since it is still within the health sector. So I accepted the offer to come to the M&E'.(Male, Kenema, IDI-5)

Some health workers also started off their careers in the health field as volunteers. They did not receive a salary from the central Government and instead received incentives from NGOs. Two interviews showed that recruitment into the civil service as salaried government employed health worker was not a straight forward process after voluntary or NGO work. This only came about after pressure from donor organisations and significant input from the health workers themselves to push the recruitment process forward.

'Well it was actually not easy, this only happened in fact when the organization that was providing the incentives for us...[...].the EU, came on some assessments and they interviewed us. We told them we are still not on government salaries, and they said they were 'giving money to the government to pay health workers salary, so why are health workers in the facility not recruited'. So they gave an ultimatum to the Ministry that they either recruit those in the health facility or they withdraw their funds, and they give to donor implementing agencies to give incentives to them, because they cannot pay the same staff twice, giving money to the government for salaries and at the same time giving money to implementing partners to pay incentives. So that brought about our recruitment. The recruitment process was fast tracked following that intervention by EU we were called to Freetown, filled our PSC [Public Service Commission] forms called to interviews and we were given appointments ' (Male, Kenema, IDI-5)

Reasons for job change

In general, job postings followed after acquiring relevant training. Job postings usually followed study leave periods. The study also revealed a number of other reasons for job postings, including self-development, being posted, being promoted, responding to pay constraints, and the effects of conflict.

Self-development

One respondent welcomed the job posting assigned to him (i.e. from clinical practice, his initial primary interest, to primary health care) and welcomed it as an avenue to further develop his skills. Albeit working in primary health care was not his primary interest, but a lack of training opportunities during his time in clinical practice spurred him to change his primary interest, with the ultimate goal of developing himself as a health worker. This view was also shared with a second health worker who felt that the training opportunities were greater within primary health care, and felt somewhat disappointed working in secondary health care setting.

'...so I made up my mind that I should also leave this place to go back to the primary health care unit because I came from the primary health care now to the tertiary feeling that things would change...[...].there[referring to the secondary health facility] I observed there are little trainings..[.....]... little encouragement,..[...]. the superintendent in charge was also the 'be and end all' and I observed that the little trainings that I was getting in the primary health care ...[...].was not in secondary health care as it in primary health care,..[...]. so I made up my mind that I should leave there back and go back to primary health care' (Male, Koinadugu, IDI-12)

A female respondent also opted to be posted to the provinces as she felt that she will gain a lot more experience and exposure in the provinces compared to working in the main cities.

'I opt to be transferred in this area.[...]....Because I was working all Western Area, I want to be exposed to get experience, different experience to know how to deal with different people' (Female, Koinadugu, IDI-10)

Posting

Job postings were coordinated and controlled at the central level within the MOHS. It was implied from the interviews that health workers had no input in the process. However, as described in a later section, there is some element of political interference in the posting process. Some of these postings were accepted reluctantly with a sense of patriotism being an underlying factor.

Some postings were based on health workers' dedication to the job and work ethic. Sometimes, they were posted to take up leadership positions at health stations that needed improving.

'It is so congested [...]...... the staff there were overloaded....[...]..... in fact that was one of the reasons why I was posted there...[...]..... because they were having a lot of complaints at the Ministry about ... hospital about the nursing staff....[...]..... you see so and by then the sister that was there I think couldn't perform so the authorities up there knowing who I am said ok please we want you to go up there this is the problem we are having up there [...] to see how best you can help in solving some of these problems so I went there to challenge the problem of indiscipline'(Male, Western Area, IDI-18)

'So based on my performance somebody recommended me so I had to join them' (Male, Western Area, IDI-21)

'Then I was even placed in the supervisory role, in the Government Hospital [...]' (Male, Bonthe, IDI-3)

Promotion

Another reason for job change was simply due to promotion, which was down to the hard work and performance of the health workers.

'Well I think it was through hard work and performance'. (Female, Kenema, IDI-9)

'....yes it was by promotion in fact as formally we, we were stagnant for so long that we thought that we would never get to this position'(Female, Western Area, IDI-14)

'....yes it was promotion as ward officer I worked there [...] well I believe by my performance and my experience length of, length of service' (Male, Western Area, IDI-18)

Lack of salary

In one case the respondent had to look for employment with an NGO due to not receiving salary from the Government, even though he was in full time employment.

'I left, because I was...I worked there for two years ..[...]... no salary. Nothing.[...] Yes....More or less a volunteer.[...]So I left, I took up appointment with MSF' (Male, Bonthe, IDI-3)

Workplace conflict

Workplace conflict also emerged as a reason for job change. In one case, the respondent experienced conflict in the workplace and decided to leave his job posting to avoid any further disagreement.

'I saw several constraints and I did not want to have a quarrel with my boss, right my immediate superior so I knew I will have a problem there and I cannot just give in to him too easily right so I made up my mind that I should also leave this place to go back to the primary health' (Male, Koinadugu, IDI-12)

War

During the war, another health worker had to move from the provinces to Freetown to avoid the conflict, and changed jobs in the process.

'....what happened next, I came to Freetown, war was ongoing [...]... I noticed there were a lot of NGOs now around. So there was one NGO, ADRA [Adventis Development and Relief Agency], [...] they were looking for a CHO, so he attached me to them, so I was working with them. So there were other NGOs that were coming, go to the provinces but you know I was, one thing I hate in my life is when you restrict my movements, so I avoided the rebels as much as possible, no matter which money you can give me, as long as I am in Freetown, I am not going back to the provinces, because I don't want to see them [...]I don't obey their instructions at the end of the day they are going to kill me.' (Male, Western Area, IDI-21)

Future career plans

The majority of the health workers in this study said they would like to continue working in the health sector. However, one respondent felt like he could not grow professionally in the nursing field and was also disappointed that his salary did not reflect his length of service. When asked about his plans for the future and to clarify his intentions with regards to staying in the nursing profession, his response was as follows:

‘...to capacitate myself yeah to capacitate myself [...] further studies [...] well this time...[...]I want to go into Pharmacy [...]... well approaching retirement I want to enjoy my retirement age engaging myself in something because a nurse I don’t think I will enjoy that, but if I do my Pharmacy I can maybe in my retirement age I can have my small drug store and engage myself still practicing...[...].....I have spent so much time in the nursing profession [...] my conscience is clear that I have played by own part, I have given my own bit to my people and my country as far as patient care is concerned you see health service delivery [...] you see I think I’ve played my own part I will not be in it forever ‘ (Male, Western Area, IDI-18)

Another was willing to stay in the health sector provided the situation around working conditions and conditions of service improved.

‘I do not plan to stay if these things [i.e. feeling abandoned by the administrative wing of the MOHS] continue, I have already started to make my mind that I cannot continue to stay somewhere where I cannot grow [...]... my plans are definite, I get myself further educated and then look for greener pastures’ (Male, Koinadugu, IDI-12)

The reasons for staying in the health profession ranged from personal reasons, i.e., being of service regardless of the current constraints, living the dream of being a health worker and having a commitment to God. These overlapped with their initial reasons for joining the health profession, which shows consistency in their commitment to work in the health care system. The majority also felt strongly about acquiring further training to help them progress up the career ladder, hold positions of leadership and train future health workers, with the hope that training opportunities will be made equally available to all.

‘...for me I don’t like to be stagnated.....[...].... I like to explore ...[...].... in the near future I would like to further my education if possible, with my Masters in Public Health and then see again which area I can help my country’ (Female, Western Area, IDI-15)

‘I love the job. I want to work for this country for my people, because I am working for my people. I will continue to work whole heartedly’ (Female, Bonthe, IDI-1)

‘I like the job, I like the job....[...]....I am still planning to stay in the job. I think...in fact I have plans to do further studies if I have the opportunity so that I can better equip myself and save a life (Male, Bonthe, IDI-3)

‘I have made commitment to the Almighty God that I want to become a nurse and today so I am going to stay a nurse for the rest of my life’. (Female, Kenema, IDI-9)

‘I like helping people who cannot actually help themselves, maybe with all their money, all their affiliation or power. Those that I love most are children and women because they are the most

vulnerable. I think if am further empowered I will help them more because at this present time we are trying but we are not doing much as we are supposed to do because of lot of hindrances; but I think we will get there' **(Female, Koinadugu, IDI-8)**

'Well now I intend to further my studies if I have the chance. For the past 5 years I have not gained any international scholarship to go and study anywhere, but I intend not to become a CHO for life. My plans are really to obtain some scholarship to go and then come back to work for the grass root people more in the form of like surgery, because for the grass root people if you say referral to the hospital for surgery they don't come, but if our capacity is built up we can do even caesarean section at community level. People can appreciate that we can take pride in doing that [...] To stay is one thing and to maintain my stay is another thing [...] Specifically I don't want to stay for now I want to further my course so that I can come back and work for my people in different form. **(Male, Koinadugu, IDI-11)**

'And so like I should have been put in charge of a hospital but because I don't want to steal anytime; I want to be there full time so that I can give out my best, so I now just decided to be working in the operating theatre. [...] Yes but from time to time I would love to teach even the theatre technicians. I will love to teach other nurses so the more of us who know these things the better for our client and even the Doctor because we are meant to make work light for them.' **(Female, Western Area, IDI-22)**

'I have talked to the Ministry I have presented my documents so that they can see where they can slot me [...] you know the world is going to preventative not curative [...] If I stay at the health centre it's mostly curative I'll be doing, but if I go now and the public health I am going totally prepared to 100% preventive, and maybe with my experience I will be able to monitor or supervise other health facilities than just staying at this one place [...] just try to develop here, but if I go further at a national level I will be able to supervise people that are doing the same work with me' **(Female, Western Area, IDI-20)**

'....yes and in fact if it were not for say the improvements in service and so on maybe I would have bowed out before that time' **(Female, Western Area, IDI-14)**

A female health worker was particularly dissatisfied with the current method for posting jobs to rural areas. She said that the length of service was based on favouritism and in some cases political interference (discussed in the demotivation section below) and was considering leaving the profession altogether.

'..... I may leave before the end of this year because there are things I don't actually like [...] Sometimes preference, if you think you are working with colleague, maybe the leader will prefer this one to you or will do certain thing for the one person and not the other, I think that is favouritism. I look it that way, so it is my opinion and I think that is not enough for me to continue being here. And I don't want to have quarrels, so I'm trying to avoid as much as possible but for now am trying to be neutral as possible and to see how thing go up to the mid of this year' **(Female, Koinadugu, IDI-8)**

5. International migration

The majority of the health workers were trained in Sierra Leone. Of the few that trained overseas, the reasons for returning back to Sierra Leone after training were centred around family

commitments, work commitments, and a sense of 'giving back' by utilising their acquired skills and knowledge within the civil service in Sierra Leone.

'Well after midwifery I thought I was qualified to come home, because I had gotten my teeth into critical care nursing, intensive care then and I would have stayed on because they wanted me to stay on but being the first child that left Sierra Leone to go out to study, I was expected to come back; and so I did.[...].So I came back home after completing my midwifery because that was necessary to come into the Civil service you need to be a midwife as well' **(Female, Western Area, IDI-23)**

'Because I was even about to do a PhD program, but then six months in that I had to say I am tired because just imagine one institution some of the professors were asking , 'Doctor are you ever going back to Africa?' Because I was in that school for fifteen years' **(Male, Kenema, IDI-6)**

'I came home, you know I had opportunities to go and work in the Arab world [...] but I had my parents and my parents [...] my father and my mother I am their only son, so how could I have left them' **(Male, Western Area, IDI-17)**

6. Overall perception of career

Health workers expressed both positive and negative perceptions of their career, with the negatives outweighing the positives. Satisfying factors were centred around personal motivation, such as religion, job satisfaction from being of service to the community, improved working conditions , money and professional development. Some of the motivating factors also overlapped as dissatisfying factors when absent (e.g. poor relationships with community, limited training opportunities and financial incentives, poor working conditions). These are explained further in the sections below.

Satisfaction

When asked 'how do you feel about your current role?' the respondents were mainly satisfied that they were earning a living, putting them in a position to provide for their families. One was satisfied with improvements in working conditions, for example as there was more being equipment provided for health workers to use, this had an overall positive impact on the health care delivery service.

'And of course I like the job because it is providing a livelihood for me' **(Male, Kenema, IDI-4)**

'..It's a little bit encouraging.....The one good thing about my job is seeing the PHU staff improve on their reporting system' **(Male, Bonthe, IDI-2)**

Others were happy about making a positive impact in their job, resulting in them having been given positions of leadership. For instance during the war, one health worker was asked to manage a refugee clinic and a government run clinic simultaneously. During his tenure, using his own initiative, he was able to improve on the infrastructure of the health facilities after securing funding from donor agencies.

'..... so the incentives stop but I still continued to be in charge there, I still continued to work and even made a lot of progress there because during that time from the money that we were able to raise from the clinic that we were saving for the community, we were able to build a structure for that community. That was my initiative and I also jointly with the organisations I was working with wrote

proposals for the construction of health facility for that community, which was done with funds from the United Nations refugee program; the health centre was built after which we also requested for fencing of that facility which was also done with funds from the UNHCR, through IMC one of the organizations that worked in the camp by then, and lastly I also requested through IMC for a staff quarter to be built for the new structures that was constructed because it was outside the village; so it was not easy to get that was but finally that request was granted and the staff quarters was built.’ (Male, Kenema, IDI-5)

Others were pleased to acquire capacity building on the job in other areas not particularly related to the health sector. This made the respondent more confident in term of administrative and managerial duties and kept them abreast of the rules governing anti-corruption, for instance:

‘...Well now it is giving me a lot of exposures and things I never even knew in the first place. I never knew things like Financial Act, I did not need it .Financial Act? No I never knew what was that. Procurement Act, I never knew what was that. But now because of this office I have been going through Auditors, Anti-Corruption [...] before it was preliminary things to me, now they mean a lot that is now am understanding what is management per se.....we have recently went through a course that was paid for by International Rescue Committee at IPAM [Institute of Public Administration and Management].....So now I believe I can reason to understand to some extent what managers and other administrators are talking, and then be able to be in their level and understanding the languages they mean and the implications of certain statements and so on and so forth. I can understand what anticorruption is saying and what the auditor is saying’ (Male, Kenema, IDI-6)

Other satisfying factors included being able to serve humanity, travelling overseas for further training, knowledge transfer from working with other qualified specialist medical personnel, progressing up the civil service career ladder and the associated benefits, skills development and its impact on their professional career development.

‘ Yes, I got a lot of experiences, like for today for what we are doing now I mean these are things you can learn, you can implement anywhere you go. You know when you do these things and you are given certificates all those add to your CV, you know, so widen your experience [...] so if you learn it , you practice it, you continually practice it then it becomes part of you [...] I am exposed to a lot of people from overseas, from abroad, especially those coming for health matters like , I’m a disease surveillance officer in the Western Area rural we are doing this surveillance, so that we are coming in contact with people, a lot of people , gain experience from expatriates coming in’ (Male, Western Area, IDI-21)

Motivating factors

The motivating factors expressed by the respondents are given below. In general health workers in Sierra Leone were predominately motivated by job satisfaction, being effective in their role and servicing their community. Financial motivation was followed jointly by working conditions and training opportunities. Another reported motivating factor was religion.

Being effective in their role

More broadly, health workers expressed satisfaction at being able to be effective in their overall role. Some were satisfied by acquiring new skills that helped them perform better in their roles;

another was motivated by being recognised in the workplace as someone who brought about positive change, in this instant by facilitating the employment of a number of volunteers attached to the hospital.

'.....but really I motivated so many people in that hospital.....only seven nurses were on payroll and then most of the people who were working at the hospital were volunteers, nursing aids, security, porters, cleaners so what I did I came back to Freetown and spoke with the personnel officer.... I think up to 58 people were appointed that year at the hospitals' (Female, Western Area, IDI-13)

Another motivating factor was the role they played in the reduction of child and maternal mortality rate and in some cases new ideas they implemented to improve the overall health care delivery system.

'Before this time maternal death was on the rampage, but over the past 2 years we've had none, we refer in time and we manage cases that are at our level the one that we cannot manage we refer them appropriately'.(Male, Koinadugu, IDI-11)

A senior cadre health worker was particularly satisfied about the role he played in dealing with additional constraints that would have otherwise crippled the work of the health facility and caused financial difficulties. Another was satisfied about the role they played in improving the working environment. Health workers in direct contact with the communities were satisfied about the impact they had, with appreciation from the communities fuelling this motivation. Another health worker was also satisfied by the role she played in training and encouraging other health workers to prepare for professional certification exams.

'I was, I was asked to help with the training of the maternal and child health aids so I did it for quite some time I also prepared people to take the Tedrow exam for State Enrolled Community Health Nurse.....I was there as a matron then at the same time encouraging people to go out for it and then I taught them'(Female, Western Area, IDI-13)

'...Having to make sure that the theatres are working, that the hospital is running, frankly speaking there have been a lot of improvements like power, now we have power almost continuously and if there's any problems we have our own generators and we have fuel to run them' (Male, Western Area, IDI-17)

Community Service

The majority of the health professionals interviewed in the CHO cadre were motivated about the vital role they played in the community in delivering care. A sense of making a positive difference in the lives of the communities they interact with, and in turn the appreciation reciprocated by the communities, was a motivating factor.

'Well, the first thing I like about this job is making difference in people's lives, helping them, to me that is gratifying for me. And when you receive people who severely need help and you are able to help those people to make them smile once again, in your life I think that's great, that's great' (Male, Kenema, IDI-4)

'The job has given me the opportunity to interact with a lot of people both in, within and outside the country that I love so much. I have been able to meet a lot of people and even the patients that I

have been providing services for the appreciation that I have got from them is something that I really admire.’ (Male, Kenema, IDI-5)

These health professionals being exposed to the community interacted with different people and including the vulnerable groups, e.g., children and the poor. In addition to making a positive difference in the community in terms of health delivery services, their work also motivated one health professional to go the extra mile and ensure that the health facility is clean and safe to minimise the spread of infection.

‘.... well what I like most is when I see a patient walking in the hospital and going back with a smile and saying thank you going back home so I really love that and I appreciate that very much and I want to see a clean and healthy environment because in order to reduce infection so I want to see a clean, especially in the maternity and all the other wards, a clean hospital and a hospital which is well staffed and everybody is motivated’ (Female, Koinadugu, IDI-9)

A number of the respondents were empathetic in nature and had great pleasure in caring for the sick. In turn they felt appreciated by the community, which motivates the health workers.

‘For working for the grassroot people, people without money, without anything absolutely, and they are seriously sick I gain pride when I see them really in the recovery especially the children, they don’t talk, they don’t tell you exactly what is wrong, when they come they are seriously ill and when you try to cure them with them, you feel pride in that’ (Male, Koinadugu, IDI-11)

‘Well at times you will be walking in the street and you see somebody in distress, you will do a little bit of counselling, you encourage people, and at times you’ll be in a house, there is a patient around, you have little or no staff you have to step in and do your own bit’ (Female, Koinadugu, IDI-9)

‘... what I like about the job is honestly speaking it’s I get satisfaction when I save lives right I get satisfaction when I get a result for my people right I get a result because I feel my people appreciate what I’m doing’ (Male, Koinadugu, IDI-12)

One CHO was particularly satisfied with the role he played in motivating staff and members of the community to effectively utilise the CHC he was posted to work in. His efforts and hard work paid off in the end as the number of patients coming through the CHC increased and the staff were motivated to double their efforts.

‘....because when I went there initially people were not making use of the facility. As I am saying [...] when you learn something and when you go to implement it, these are two different things [...] when I went to Tombo HC [health centre], it was as dormant as people are not using it, they said they preferred going to those quacks, because we had a lot of quacks around. So when I went there people are just sleeping, all day nurses sleeping on their benches, so I said ‘No we must do something, let’s go into the community, and motivate them.’ So we went [...] we encourage them, they recover from their afflictions or whatever, we conducted difficult deliveries, they say ‘O something is happening here’. So that is the time they started using the facility [...] we had community meetings with the people, tell them that the facility is there for them to use. If they use them then they will ask for more and the Government will give them, but if they don’t use the existing one, how can they ask for more. So they started using the community and it kicked off from there. Now today it’s one of the highest areas where pregnant women are given birth to children [...]

we only have to double our efforts [...] because the more you give quality service the more you treat somebody quickly the person recover from his or her illness [...] So that is why when you come we make sure we give you the best you can get so that you can't stay long in the hospital and give space to somebody coming in. So that is the way we are coping' **(Male, Western Area, IDI-21)**

There was a general sense of pride in achieving the goals being a health worker entails and in one case this motivated the health worker to put in long hours at work. The health professionals in this study were motivated by having a positive impact on the overall health of people; in one case the health worker was satisfied helping the poor and sick health service users, with one health professional caring for people in this category free of cost, another took great pride in diverted health service users to health facilities and not quack doctors they had previously sort their health services from.

'Whenever I contribute to saving the life of a patient I am happy, especially during delivery. It makes me happy [...] Even with the community to be frank enough, the community can be so friendly. If you go to a community at times they receive you happily. You talk with them; they will explain their problems to you. There is a lot, in this profession you will come in contact with a lot of people' **(Female, Bonthe, IDI-1)**

'A lot, a lot of new ideas are coming, which if we implement that it will be of great help' **(Male, Bonthe, IDI-3)**

'For working for the grass root people, people without money, without anything absolutely, and they are seriously sick I gain pride when I see them really in the recovery especially the children, they don't talk, they don't tell you exactly what is wrong, when they come they are seriously ill and when you try to cure them with them, you feel pride in that [...] That is a pride, people are now seeing the essence of our work and they appreciate much'. **(Male, Koinadugu, IDI-11)**

Financial incentives

Financial incentives, in terms of salaries and salary uplift, were also motivating factors for the health workers involved in the study. The majority of the health workers saw a decent salary that was paid on time as positive as it meant that they look after their family, that wives could relieve some of the financial burden on their partners and that they could provide better education for their children. As one respondent put it, educated children will later be in a better position to serve their communities in a positive manner.

'I want to have a decent salary that will enable me to plan the lives of my children so that they too can be in the position to be of use to their communities in the future.' **(Male, Kenema, IDI-4)**

'.....yes if I'm motivated yes it will improve my livelihood because if salaries and remunerations are being paid on time and, and especially my salary is being and is increased its that means I will satisfy my children even if I am away, I would have satisfied in my, even assist my old man in paying the college fees and school fees for my children' **(Female, Koinadugu, IDI-9)**

Working conditions

Improvements in working conditions, including in the infrastructure was captured as a motivating factor in this study. This, accompanied with improvements in water supply, power supply and diagnostic tools, was welcomed by the health professionals meant improved service delivery.

‘..... it was a bit encouraging because the time I was there we only have one maternity ward but by the time I was leaving they had already constructed another new maternity ward’ (Female, Western Area, IDI-15)

‘.....yes as I said earlier, the hospital has changed for the better, in spite of all the problems we have been making some strides, forward strides and when we came here long ago, we don’t have ultrasound facilities, now we do, we didn’t have a CT scan, now we do and ...we had maybe 1 or 2 or 3 anaesthetist now we have over 10 you know. They are definite areas where we have made strides. In 2006/2007/2008 there was no running water in the hospital, now we have. In 2006/2007/2008 the power supply was a big challenge, I remember doing a kidney operation having to do it under a torch light because there was no electricity [...] today such occurrence is rare you know’ (Male, Western Area, IDI-17)

Training opportunities

Capacity building by participating in short continued professional development courses was also a motivating factor for health workers. International training opportunities were particularly welcomed by one health worker she perceived it improved her CV. On the job training acquiring life-saving skills was equally valuable.

‘yeah like even to improve our capacity in form of training I would appreciate that very much as I was emphasising when I was privileged to attend a course in Ghana. It was really, it’s serves as a motivation to me going and when I came back I was really happy ‘cause I thought at least I’ve had something in my CV’ (Female, Koinadugu, IDI-9)

Religion

In addition to being an influencer in the decision to become a health worker, religion also emerged as a motivating factor. One Christian respondent was thinking in a Christ-like manner whilst caring for the sick:

‘..... I don't want to be religious, but some of us as Christians, you know Christ was healing people, the great physician, and if I do delivery and the baby survives, anytime I see that baby going about, growing up I feel proud.,..... So all those things and because we have families, we have children, maybe that's why I'm....that blessing will be extended to them’ (Male, Bonthe, IDI-3)

Dissatisfaction

Poor working conditions was the most frequently reported demotivating factor, followed closely by limited training opportunities (especially for health workers in rural postings due to regional disparities) and poor monetary incentives. Out of the 17 respondents that reported poor working conditions, 11 were currently in rural postings. Another demotivating factor is poor management. This was reported more by health workers working in the Western Area (9 respondents out of the

23) compared to the rural posted health workers (6 out of the 23). An explanation for the rural setting could possibly be that the health workers concerned have often assumed leadership positions and are therefore managers rather than managed.

10 out of the 13 respondents that reported 'limited training opportunities and lack of career progression' as a demotivating factor and 7 out of the 12 respondents that reported 'lack of financial incentives and benefits' as a demotivating factor were in also rural postings. This suggests that improved working conditions, good remuneration (relative to the cost of living) and professional development and career progression should not be neglected for health workers, especially for those working in rural, hard-to-reach areas. The next demotivating factor was political interference, which was reported by more respondents from urban areas (5 out of 8). It can be assumed that city based health workers (in Western Area) are in closer proximity to the governing arm of the health sector and will therefore experience more political interference. Relationships with the community were reported as a demotivating factor more commonly by community health workers. Separation from their families was reported as a demotivating factor mostly by rural posted health workers or in reference to an experienced rural posting. Other reported demotivating factors reported by both rural and non-rural posted health workers include: limited levels of autonomy; lack of security as a result of conflict (job and personal), poor working conditions (e.g. lack of transportation provision for health workers in rural postings); poor retention of staff (especially in rural areas); tension in the workplace; lack of career progression; long working hours; difficult recruitment processes (which feeds into reduced retention of health workers especially in the rural areas); and challenges surrounding the rural posting process.

Demotivating factors

Working conditions

Health workers are exposed to working conditions that cannot be managed wholly by health workers as little support was received from the MOHS.

'.....but we were working in conditions that we cannot manage all by ourselves. We needed drugs, we needed support staffs...' **(Male, Kenema, IDI-4)**

One health worker described hospitals in the provinces being unhygienic (pre conflict) and another described running a health clinic in a dilapidated building for five years not a conducive working environment. The building was heavily infested with rats with unsuitable flooring, no running water and no ceiling. This building also served as accommodation for the health workers.

'..... and also where we were having the clinic was a community building. It was not conducive for the work, the building was infested with rats, in fact there was no cement on the floor sometimes we had to spread tarpaulin on the floor, at least to have a good surface to work in and there were no ceilings [...]and we were all living in that building [...]Water was not available until sometime when MERLIN had to dug a well and build us an incinerator also. For all the 5years I was there, I spent in that dilapidated building; it's heavily infested with rats and lots of things.' **(Male, Kenema, IDI-4)**

Health workers working in rural areas were particularly demotivated by the lack of accommodation provision made for them. This contributes to the observed pattern of newly posted staff not assuming their posts. This resulted in health facilities being under-staffed, a common occurrence in the provinces. One medical officer recalled having to wear many professional hats during his rural posting.

'.....we don't even have enough staff. They can post nurses here but because of accommodation they will come and go and come no more because they don't have where to stay. We have reported that at the national level time without number, but no action is being taken' (Female, Bonthe, IDI-1)

Health workers who trained initially overseas felt there was no motivation or incentives for health workers. Health workers worked without taking any leave as there was no leave allowance. Hospitals were in a deplorable state, unhygienic and lack necessities such as electricity and water supply and functional equipment needed to run an effective health facility.

'..... as far as I am concerned there is no conditions of service it's almost nothing, believe me it's like you are coming from somewhere much, much more advanced than here and you just come everything is so different [...] there is no motivation, people are just doing whatever they want to you know. Doctors were admitting their own cases taking money from patients and nobody even wanted to go on leave because there is nothing like what do they call it leave benefit [...] nothing like leave allowance you cannot get a government quarter (accommodation) [...] there is nothing medical for you (as in no medical insurance). I mean there was nothing, the hospitals were all dirty and full of rodents [...] there was no light [...] and er nobody wanted to listen to you, the government didn't want to listen to you I mean nothing. I came all the way from there to come back and help my country I don't even have accommodation [...] although we have well improved from 10 years ago to now but up to now we still don't have mechanisms in place that will attract or that will stop our people from leaving. Still we are still behind a little bit, although when it comes to provision for those we actually give service to, the patient, I can say we are much, much, much more better when it comes to those who provide the service we are still behind' (Male, Western Area, IDI-19)

Hospital administration has had to deal with delays in receiving subvention from the Government making it difficult to run an effective and efficient health facility.

'..... you see and in those days government subvention coming maybe only twice a year when we are supposed to have it four times even the second sometimes come the other year ..so it is very, very difficult in those days to run the hospital, very very difficult you see' (Male, Western Area, IDI-19)

Transportation or lack of transportation was also an issue for these health workers. Some had to resort to walking to work or using motor bikes to personally fund their commute, which could be expensive. One health worker reported being initially provided with a motor bike and fuel, but this service was not sustained by the MOHS. Ambulances were not provided to some health facilities, making the transportation of patients a challenge. The road networks are poor and no means of transportation were provided to a health worker who had to visit 68 PHUs as part of his duties. This had a negative impact in his performance in conducting his supervisory duties.

'The terrain, the road network because if you don't have road worthy vehicle you cannot move then and the work load is so high because you have to visited all PHUs; we have about 68 of them and

the personnel staff, the PHU staff are complaining all the time about the number of clinic attendances which is too much for them'. (Female, Koinadugu, IDI-8)

'.... I was working in the main referral hospital, there was a little bit of constraint you know most of the peripheral health unit the health centres when they are tired with most cases they do send them to the main referral hospital, to get an ambulance to go to the far extreme point was a little bit difficult' (Female, Western Area, IDI-15)

Communication was described as poor due to very limited mobile phone coverage in some of the hard to reach, remote areas. In the provinces, health workers stay in staff quarters which are usually in close proximity to the health facilities, have to work round the clock and deal with out of hours cases. One health worker described working in the provinces as 'retrogressing' as essential services such as electricity and running water are lacking. Lack of electricity or a generator means health workers were having to improvise on the job and some reported having to use torch lights from their mobile phones and lamps as a means of providing light during important surgical procedures such as child delivery. In one case, this alarming issue was resolved by the installation of solar lights.

'.... at times I want to work but if you don't have the instruments, the materials you see [...] they will give us electricity during the day, but for night, no. We have to use our torch. But thanks be to God the former chairman who was here came here and saw the way we were suffering, how we used to use our mobile torchlight put it in our mouth to do deliveries in this place. But now thanks be to God he assisted us to get these solar lights that we are using at night' (Female, Koinadugu, IDI-10)

'When you even want to make certain calls you have to go a mile to stand at a distance before you can even make communication so that is complete cut-off, its retrogressing [...]the working condition is very poor, no mobility, you live like any poor man, no light, no water supply, even if you, at the clinic you improvise; a lot of the equipment that you need to work with to really perform your best they are not there unless you have to improvise and government is not putting those things in to place' (Male, Koinadugu, IDI-11)

The majority of the health staff reported a lack of basic functional equipment and training in basic life-saving skills like vacuum extraction being provided in the health facilities. In addition functioning modern information technology-related equipment was also not forthcoming. Lack of equipment, low staff numbers, lack of drugs and medical supplies and administrative support in health facilities were reported to make work difficult and to result in patients not receiving the best available level of care.

'... the condition of the hospital was a little bit better but there was still challenges as an administrator in a ward within a ward setting ..[...].....you have to ensure that each and every patient receive appropriate care, by then there were shortfalls for the hospital administration ...[.....]..... these challenges you know and that actually made work a little bit difficult to us' (Male, Western Area, IDI-18)

'.... we need to be getting some basic equipment that we are supposed to use, like for instance, if you go to Tihun now, you will hardly find minor surgical instrument. We have been trained really but we need more training in this vacuum extraction but it is not available. We are trained to do implant, family planning ...[...], but these things are not there (Male, Bonthe, IDI-3)

'And with the profession, you don't have the equipment to perform efficiently and some of us are committed we are ready to do the work, but the basic equipment is not there, so we cannot do our best'. (Female, Koinadugu, IDI-9)

'.....working conditions were not what can I say, optimum, we had to buy our we had to buy gauze we had to buy gloves you know all the things we use for our work.....out of our own pocket, if you didn't buy them you wouldn't get them..[.]....2000 and up to 2004 although up to now we still but, but it's not as it used to be....[....]....from time to time they bring gloves although the supplies are not continuous but at least they are coming from time to time' (Male, Western Area, IDI-17)

'There are certain gadgets like computers and modems that will enhance me to do the job better, but these things are not forthcoming. Sometimes they send the gadgets but they are not fully operating and replacement is not forthcoming' (Male, Bonthe, IDI-2)

The progress of health facilities being upgraded to fully functional Basic Emergency Obstetric Neonatal Care (BEmONC) centres was impeded due to a lack of logistics to facilitate the implementation of new services. Lack of adequate space in health facilities was also a challenge; one health worker reported having to improvise to maximise the use of space for certain activities to be carried out in the health facilities.

'.....yes as we said sometimes we need materials that we cannot get, materials yes drugs and supplies or regular things that will make the working environment convenient for us so that we will be able to practice all what we are supposed to do; like space is not adequate here because being choosing here as a BemONC centre we should do more than the other health facilities but there are certain activities we cannot implement properly like adolescent health we don't have space for it [....]we just manage as you see us using outside, make compartments, immunisation is here registration is here, testing is here, blood tests, medication, giving treatments; they should not really be outside, it's already very inconvenient because of noise and interruptions but we just have to do it because we should do it' (Female, Western Area, IDI-20)

A health worker working in the Western Area also reported the need for a district referral hospital serving the rural Western Area to minimise the number of casualties that usually occurs whilst transporting patients to hospitals in Freetown.

'Well is it more challenging, because it's like the district headquarter is far much bigger, and the staff strength is bigger, the workload there is more heavier, there are a lot of challenges, as I was saying in the whole district now there is no district hospital unlike other districts in the country; that is the only district that don't have a district referral hospital...[.]... as I am saying the need for this district referral hospital because all these things if we have our own hospital there, just move from there to the next place instead of referring somebody all the way, sometimes along the way from there to Freetown somebody die along the way, especially this huge traffic along the way' (Male, Western Area, IDI-21)

Another health worker whilst on a rural posting had to deal with cases that were referred late and in most cases there is very little that can be done then to save the patient's life. In other words, this prevents health workers from being effective on the job.

‘....what I don’t like is when cases are bad, then they send them as late referral they expect you the nurses to do your best but if some cases are sent to you they are in that moribund state you can’t do anything except you help if by the grace of God that patient survive if the patient didn’t survive you don’t have any other option’ (Female, Western Area, IDI-15)

Poor management

Professional relationships emerged as a demotivating factor in this study. Junior staff members felt neglected and unappreciated and thought senior managers should do more to motivate them. There was one report of supervisors humiliating junior level staff, with the respondent describing the managerial structure as bad, due to favouritism in the workplace and bureaucracy in accessing funds.

‘Sometimes preference, if you think you are working with colleague, maybe the leader will prefer this one to you or will do certain thing for the one person and not the other, I think that is favouritism . I look it that way, so it is my opinion and I think that is not enough for me to continue being here.’ (Female, Koinadugu, IDI-8)

‘....but what I don’t like about the job is that we who are the cadre that is down there, who are seeing the bulk of these patients [...] we feel abandoned. We feel people do not care about us, when you raise eyebrows about certain things, people say you are poking your nose right into areas you should not poke your nose [...] nobody talks for you. That is the funny thing about the Ministry of Health, it is the expectation that if we raise issues that are bothering us in our health facilities, the administrative wing of the Ministry of Health, those people who are our supervisors must be taking these things forward and agitating so that these things will come, but this this does not take place, this does not take place’ (Male, Koinadugu, IDI-12)

‘.... we only need constant motivation from our immediate bosses, of course sometimes some bosses may tend to be humiliating to others. Instead of them motivating you to work they tend to be humiliating for one reason or the other [...]you allow somebody to hold everybody to ransom [...] nobody can work, nobody can say anything, because you are the boss. Whatever you say nobody ever needs to say no, you don’t consult people in anything, so that is autocratic way of doing things and that is bad management as far as I am concerned, because if you are planning, you are planning alone then when you come to the implementation that’s when you know you had a very good plan or poor planning. So that is what I am saying, if we are working as a team, medical work is a team work, if you are planning you plan as a team, you implement as a team, you evaluate as a team; but if you plan then you are asking me to implement, I may not even know where I may go wrong not so...[...].... all this because of favouritism, you favour one group of people, they are all vibrating on the same frequency but you give preference to them, when benefit comes to the unit you prefer them, you know, you try to demotivate others, that is the type of administration some of us are seeing in our own little corner, not in all areas ’ (Male, Western Area, IDI-21)

‘My dislike is sometimes the bureaucracy in terms of accessing fund [...] It can be my boss, to the council, sometimes the relationship within the district health management team [...]... Sometimes preference, if you think you are working with colleague, maybe the leader will prefer this one to you or will do certain thing for the one person and not the other, I think that is favouritism. I look it that way, so it is my opinion and I think that is not enough for me to continue being here[...]...And let people do what they are trained for, let them perform, allow them perform their duties. Don’t just

keep people in place and move their duties to other junior staff and expect them to perform how you want them, it can't work. This one is a bit crucial, because if it comes to funding you can see junior staff handling funds, you don't see, but you will continue to do your work, because you've sign to work but is not good' **(Female, Koinadugu, IDI-8)**

Health workers in this study felt that they should be involved in the decision making processes that governed the management of the health facilities. There was no delegation of duties or teamwork, with doctors taking on senior managerial roles, including financial management, without the involvement of other supervisors, creating a managerial situation described as 'dictatorship'.

'And even at that now we have the councils, and the councils yes they provide the funds but I think they should listen to us the professionals instead of the support staff...[...]. Well its seems as if the professionals are left behind, while those who went for administrative courses, who went for academic courses are at the top of the ladder whilst we are down so that one is not encouraging; it is demotivating for us as professionals' **(Female, Kenema, IDI-9)**

'.....one of the major challenges was there was no relegation of responsibilities to other cadre. What we observed it was only the doctor that was doing everything, even the finances, the budget, everything was just the doctor.....' **(Male, Koinadugu, IDI-12)**

One respondent gave a different view on this issue; she felt that nurses were to blame as there was no autonomy within the profession and that nurses not acting in their professional capacities results in doctors having to make all the decisions. Doctors have to approve everything and sometimes decisions made by doctors were based on selfish gains.

' Sometimes I blame nurses themselves because when you come into the service, at the office of the, the Public Service Commission then, where you are interviewed, you are given certain conditions and you accept it. Why is it then, when you are supposed to fulfil those conditions you need to go to the doctors you know so they could change things your way? I believe if nurses were cohesive the doctors will not have any leeway, but many a times it's the nurses who go to these doctors so that they get things changed to suit them....[...]. Well like I always say nurses do not have autonomy. It's like our position is being used up by doctors all the way even at that level. I need not talk about what happens within the hospitals. Decisions that should be made by nurses were always changed by doctors to suit themselves even if it's their relations or friends..[...]. You sort of have to go along with this because like I say there is no autonomy, and if you not like practically dance to their tune you do not even get the necessary logistics you need to work in your office, because at the end of the day whatever the nursing directorate wants a doctor has to sign, and sometimes they kept my papers there for a while, sometimes I will lose a whole quarters subvention for the office simply because I spoke up at times. So nursing for me needs total autonomy, if things should go the way they should, because even with your good intentions, if it doesn't suit them or somebody they know, they will never allow it to happen. **(Female, Western Area, IDI-23)**

Limited opportunities for training and lack of career progression

Working in the medical field, health workers felt that training or refresher training is a vital component for their professional development and to keep abreast of changes in this dynamic field. Health workers reported that opportunities for further professional development were limited. Some were willing to pay for their further education but are not financially able to do so.

‘...preference should be given to some of us who have been in the provinces for so long so that we can go for further studies. (Female, Koinadugu, IDI-7)

‘Secondly, the MOH is not helping us to improve your status. As a community health officer, after 5 years they should have given us the opportunity to go and improve our selves but these are also not forthcoming...[...].In every field you find yourself there should be opportunities allowing you to grow in the system meaning you should be given the opportunity to acquire more knowledge, to enhance you to do a better job. You should be given the opportunity to grow professionally’ (Male, Bonthe, IDI-2)

‘ firstly in any profession you are you expect to grow, and therefore you expect that government should help to build your capacity [...]since we came out [as in graduated] I don’t think government has given us anything to help us to motivate us in terms of building our capacity..[...].in our training we are told that for every three years right you must be sent so that you will build your capacity in terms of your work but that has not been taking place’ (Male, Koinadugu, IDI-12)

Limited professional training opportunities emerged as a demotivating factor with regional disparities (10 out of the 13 respondents were working in rural areas). Health workers posted outside of Freetown were of the opinion that training opportunities were only made available to those working in Freetown. In general, health workers in the hard to reach areas feel that there is a lack of professional development as they are overlooked for training opportunities by the MOHS.

‘... I don’t have opportunity. In fact you people down there (as in you people in Freetown), we are here working; whenever there is an opportunity, to go for further course, we are not remembered. Everything is staying in Freetown. But we don’t mind, we know that one day our Lord will see us through. Me in particular...[...].If there is any provision it lies in Freetown and they forget about us..[...].in terms of short courses overseas or even in the neighbouring countries, they don’t remember us only you people in Freetown. And we are here. Are we not part of the nurses, are we not part of you people? Please try and think of us....[...]. When we hear our colleagues going for studies even in the neighbouring countries, and we are not it is a challenge to us, as it means that if all of us where there maybe they will remember us. But we hope and pray that they will remember us one day’ (Female, Bonthe, IDI-1)

‘.....and also we are not furthering our course, I don’t see any need to stay but if can go and further our courses, afterwards we can come and work for the community in different form we can appreciate that [...] maintaining you is that you have to be build my capacity that I will come back and work’ (Male, Koinadugu, IDI-11)

Graduates from other non-medical disciplines are employed within the health sector and qualified health workers in charge of supervising them are not given the opportunity to grow professionally. This equates to limited career progression, particularly within the CHO cadre of health workers

‘They as technical people in the Ministry do recognize the role we are playing and that without us the supervision of PHU and monitoring of health activity within the district will not be effective. With these new guys coming in who have no health background, in fact their trainings are from other disciplines [...]. But unfortunately I have personally never grown and likewise my colleagues CHOs. Ever since upon graduation we have been on the same scale salary scale there has been no

promotion, no salary increment apart from the general salary increment that was done for all health workers in the country with the free health care coming in. There was no difference between old CHO, senior CHO or CHOs just coming from the classroom. Everybody was placed on the same scale; so that was also a very discouraging thing for some of us who have served for so long, seeing somebody just graduating from the training school coming and you are all placed on the same salary scale; that one was somehow demotivating [...]. And also from the government point is that those that supervises our job can come around and praise you and say that you are doing very well, but very little have been done by them actually to give you support for further studies or to actually give you that recognition and recommend you for scholarship and other things.' **(Male, Kenema, IDI-5)**

Health workers working in Freetown also reported that even in Freetown there was a lack of transparency regarding available training opportunities. Training opportunities and scholarships are not equally made available to all health workers probably/presumably due to the political interference discussed below.

'it's a little bit challenging maybe before the those er training will come you will not be aware there will be people that are not that are not even qualified to go for the training they do sent them' **(Female, Western Area, IDI-15)**

'.... we are not much motivated you know like capacity building, I mean, I know scholarships comes in this ministry they don't look for the right people to give you know, and even when you try by your own way to go and study they say we won't give study leave, I mean these are like demotivating things..' **(Male, Western Area, IDI-21)**

CHOs were also dissatisfied about the lack of a governing body for CHOs as there is lack of a career progression and for CHOs. Those in charge of CHCs found themselves working for less pay compared to nurses that they were supervising. One respondent felt that there was no appreciation on the job causing health professionals to leave government postings to seek employment with NGOs.

'..... what we are looking for as CHOs countrywide is actually to give us a scheme, we should have a structure in place...[...].....we cannot just be working in one place without being promoted from one level to the other; so we want to have a working scheme..[...]..... one thing that is discouraging, you have somebody who you are supervising, she is paid far better than you, you know; these nurses, you can have a grade 7 nurse, I am grade 5..... so you see, this is so discouraging because they have a board, nurse board, people pushing their own cases we are working at periphery health unit, doctors are not going to periphery health units, we are doing the basic things...[.].....we are doing everything. We have a wider job description to do....[.].....So that is our problem, that is why most people, most of our colleagues they prefer going to NGOs, they say we can stay with you as an association but with these conditions with no promotion' **(Male, Western Area, IDI-21)**

Again, the CHOs voiced their concern about lack of job security due to the absence of a governing act for their profession.

'We don't even have an act to go to govern us, we don't even know if we can be promoted or not, we don't even know if there is any future in this career, so it's disheartening' **(Male, Kenema, IDI-4)**

Lack of further professional/career development was reported as another factor influencing health workers to seek employment with NGOs.

'As I have said before, in every system you find yourselves there should be mechanisms for people to grow in the systems, from one stage to another, but that is not happening. This causing people to leave the Government to seek employment with other NGOs; if you are in stage one you must be given the opportunity to go to stage 2 as long as you are qualified and ready to do it. Currently when someone is in one stage nobody cares. You do a good job but you are not compensated for that' **(Male, Bonthe, IDI-2)**

Another CHO was discouraged by the poor salary scale associated with his profession and the lack of adequate professional certification at the end of his training.

'Because of the interest of the job, and with promises made that that was a temporary measure taken by the Government, that they were going to look in to those things and they were going to do adjustments on the salary scales; we have been waiting for that for the past 3years now but nothing has been done with regards that. ...[...]... The course we did was equivalent to a degree course. Looking at the course curriculum all the training that we went through was an equivalent to a degree course but we were just given a mere certificate that was not even recognize by our university in this country, so that was very frustrating and in fact that was a point in my life that I regretted going in for that training. I thought initially I had wasted my time for nothing, but because there was no other way out and that was the certificate I used to get employment in to this Ministry..' **(Male, Kenema, IDI-5)**

Limited financial incentives and benefits

Health workers working in rural postings and those working in Freetown expressed lack of financial incentives as a demotivating factor. About half of the respondents in this study expressed this as a demotivator.

'.....incentives that are there to encourage us to do the work are not forthcoming. Thirdly our salaries are fixed when the cost of living is increasing' **(Male, Bonthe, IDI-2)**

Health workers reported no significant change in their salaries over a 10 to 15 year period (in the pre-salary uplift period), showing that there is a history of poor remuneration for health workers. Medical doctors were reported to be earning the equivalent of \$100 per month before the salary uplift that came with the free health care initiative. Health workers were promoted based on further acquired professional development with no change in their salary.

This issue was addressed by the Government of Sierra Leone (GOSL) with the salary uplift in April 2010, which was welcomed by health workers. However, the general consensus is that this is not in line with the increased cost of living and is not commensurate with the duties health workers perform. One respondent expressed grave disappointment in the slow rate of salary increase, arguing that it was not in line with increased responsibility or length of service. Having been in active service for over 10 years, his monthly salary was still below \$200, despite the salary increase. The salary was described as a 'pittance', 'not encouraging', especially when compared to the private sector (e.g. NGOs) salaries, not on time and in general not sufficient to support family financial responsibilities.

'Well looking at the salary is it just a pittance, there is no motivation.' **(Female, Kenema, IDI-9)**

'...Because it's sacrificial. And you know government salary as compared to private sector is not encouraging but since we are sacrificing for the state, we are doing it because we are working for our people, but not to be compared as those that are working for the NGO's' (Male, Koinadugu, IDI-11)

'Nursing hasn't got money. There isn't much money in nursing' (Female, Koinadugu, IDI-8)

'Salary by then was small, and at that time it was difficult when we started, because there are times you work, at the end of the month you are not paid. The salary are not coming, they will go in to the next month like the 15th – 16th before we are paid [...] salary changed over that 15 year period, but it was very slow, it was not encouraging, according to the condition of living in a country or the standard of living. It didn't match so at the end instead of improving the lifestyle of the staff, it deteriorated [...] it cannot match with inflation' (Female, Western Area, IDI-20)

'No changes in the money it was the same and the same uniform [in reference to after a promotion at work]. You wear the same white and red belt. Some of us find it strange because when you do another course we will be expecting that more money will be given to you [...] we just continue like that. Some people did not even notice that we did any training' (Female, Western Area, IDI-18)

Health workers felt they were underpaid, which has a negative impact on their commitment to the health care delivery sector. Some stay and work for patriotic reasons and others have to engage in additional employment; it was reported that health workers in some health facilities only work for a few hours in their posted stations as they are engaged in employment elsewhere.

'...salary was a problem because staff were underpaid, in fact, some of them leave they come and work for a few hours and they go elsewhere where they get more incentive' (Female, Western Area, IDI-20)

'Salary is not encouraging it's just a matter as I say I've made up my mind to give my service to humanity you see I have a call for the profession other than that I would have quit long ago you see.....[...]. I believe as I say it's work of humanity the Almighty God will pay me for my work but if it is for money I would have quit this nursing profession long ago you see maybe one or two years after my training when I started working as a staff nurse..[...]. and you earn less than \$200. After so many years of service I earn less than \$200 it's very appalling' (Male, Western Area, IDI-18)

Others would like to engage in other activities to make money but the workload at the health facilities prevents them from doing so.

'... I primarily rely on the job to make money. I have been thinking about doing other things in order to make money to support my life and the lives of my children, but the time the work is demanding cannot allow you to engage in some other activities because if you are coming for work from 8 to 5 in the evening, what else can you do to make money. If you have to be on the job from Monday through Saturday and even on Sunday you can expect emergencies and other things. It's not easy for you to engage in some other activities to augment your earning power. I only believe probably if there is a way you can be supported to make enough for yourself, I think you will love staying in the job for a longer time' (Male, Kenema, IDI-4)

With regards to other financial incentives, health workers in rural postings reported that the remote area allowance was not forthcoming and did not make much difference in the monthly income of

health workers working in remote areas. It was also reported that in the case of PBF, health workers in Freetown receive the PBF allowance sometimes a year earlier than those working in the remote areas, which has a negative effect on the performance of remote area health workers.

'I am not saying you, but rather that the Ministry should think of us please. We are doing the job. Let's have some motivation. In fact we heard about remote allowance, but don't know how to get the allowance. Let the Ministry think of us in the provinces please' **(Female, Bonthe, IDI-1)**

'....even with the advent of the performance based initiative when it had been paid almost a year in Freetown it had not been made available for us right ...[...].and we are not seeing none of these things on our salaries; we do not see the differences between this and our colleagues elsewhere and we are we are living in very hard to reach areas which are not easily even navigable by even motorbikes **(Male, Koinadugu, IDI-12)**

This health worker went on to further admit that health workers do not stay in their posts sometimes, due to being demotivated on the job:

'....it is very very demotivating[...] it makes you not to like the job; had it not been for the love of your country, you see people suffering and you cannot really see your people suffering you can easily abandon the job and leave the job [...] No incentive, no motivation so what happens generally is most of the times when you stay 1 - 3 weeks in your rural posting and then you leave your posting for one or two months before going back, because there is no motivation and people start to grumble that you are not in your workplace but you are not motivated' **(Male, Koinadugu, IDI-12)**

Newly recruited staffs are usually not paid on time and situations where health workers have to give incentives out of their own pockets were reported. One health worker reported that porters and security staff recruited in April 2012 were still yet to receive their salaries over a year later in May 2013 (when the interviews were conducted). This situation gives an increased financial burden on health workers as they have to give these staff members incentives out of their pockets, despite their own poor salaries.

'....the other issue is about the recruitment and even the payment of salary because if I can remember some time last year, they recruited nurses and the auxiliary workers like the porters, the cleaners and the security..[...]....sometime in 2012 April they recruited some of these like porters and securities but up till now their salaries have not been paid. So sometimes they will come to you they think we are responsible for their salary and to pay them...[...].we will send PIN codes, NASSIT numbers to the payroll or payroll office or even HRM office in Freetown but up till now we are making phone calls. So you see sometimes the people are pesting us especially those junior workers, the porters and securities so you see we are having problems and we are not responsible for their salary, they will just think we are having the salaries and we are not talking we just don't want to pay them so you see these are some of the problems you see ..[...]....it's not easy sometimes we have to talk to them we will give them incentives, sometimes from our private purses or sometimes when Council budget is being released sometimes we will give them incentive but it is not easy because if the salaries have been paid it will assist, it will motivate them...[...]. can you imagine someone working a whole month without receiving salary, it's not easy not even easy for the management' **(Female, Koinadugu, IDI-9)**

It was also reported that some health workers received no salary from the Government. One respondent reported that the European Union (EU) had provided the GOSL with salaries for the volunteers attached to a health facility but said funds were not made available until the issue was queried by the EU.

'Well it was actually not easy, this only happened in fact when the organization that was providing the incentives for us. The donor organization, the EU, came on some assessments and they interview us we told them we are still not on government salaries and they said they were giving money to the government to pay health workers salary, so why are health workers in the facility not recruited. So they gave an ultimatum to the Ministry that they either recruit those in the health facility or they withdraw their funds and they give to donor implementing agencies to give incentives to them because they cannot pay the same staff twice, giving money to the government for salaries and at the same time giving money to implementing partners to pay incentives. So that brought about our recruitment.' **(Male, Kenema, IDI-5)**

Health workers were also dissatisfied that measures were not in place to provide them with medical insurance.

'And again working as a health worker one big challenge is that with all the risk that we are faced with in dealing with different kind of condition, there is no medical insurance for me as a health worker. If anything happens to me it has to be me and me alone, except if somebody from my family decides to assist me but there is no provision. Even like when we go out on supervision you get involved in an accident there is no insurance covering us for that; so that is a very big challenge' **(Male, Kenema, IDI-5)**

'...well there are no encouragement for staffs...When you are sick you have to foot your bill, you have to foot your bill you have to care for yourself' **(Male, Western Area, IDI-18)**

Political interference

Comparisons were made pre-conflict and post-conflict on political interference. In general, it was felt that political interference was minimal pre-conflict. The situation post-conflict is that health workers are subjected to political interference at different stages of their professional lives ranging from securing scholarships for further study, promotion and recruitment opportunities and disciplinary action. Political interference comes from those high up in society (e.g. politicians and permanent secretaries) and even from doctors. Health workers with political connections were reported to not adhere to disciplinary action, which further fuels the problem of poor discipline in the work place as the chain of command is lacking.

'...but in Freetown everything is free, everybody is free, even the nurses some of the because of either contacts or whatever they will not even want to listen to you...formally we have relatives who are parliamentarians we have the relatives who are ward people related to the CNOs or CMO and whatever but they never interfered but nowadays people just look at you as if you are nothing ...even if you are doing the right thing you try to correct them you try to bring them to what you want and they think that is not correct ... phone calls, complimentary cards, letters of threat and queries will come over to you and so some of us think about that before taking actions that is why there are times when some people are let loose' **(Female, Western Area, IDI-14)**

'Well now when a nurse goes out the way, you want to discipline that nurse, you get order from above, whether you like it or not; order from above; interference, seniors are not allowed to do their work, the chain of command is lacking, there is no stand of control. They can even bypass you and go to higher authorities; so that one is absent, and I am appealing for the Sierra Leone Nurses Association and other partners to come on board so that we start from the entry points to scrutinize these nurses coming in thoroughly'. (Female, Kenema, IDI-9)

'From superiors either professional like the doctors or even the permanent secretaries, they interfere. I mean somebody who knows nothing about health care; they tell you what to do...[..]...You cannot just send nurses to a specific area within a hospital and you don't even know the needs of that particular institution at that time. And they are still doing it' (Female, Western Area, IDI-23)

Doctors were reported to interfere with the roster system in the health facilities. Job postings were changed due to political interference and a lack of transparency in the promotion process meant hardworking health workers were overlooked for promotion in favour of those with political backing

'Some people may have misbehaved in the work place but because they are connected they will go with the promotion they gave them you just see them promoted and you don't know how and you have been working hard.' (Female, Western Area, IDI-18)

Relationship with community

Health workers also have to be tolerant in dealing with the communities with which they work. Some have had to deal with confrontation from family members of patients and community members intruding into the personal lives of health workers. Others felt that they were being monitored by Monitoring and Evaluation (M & E) Officers, presumably selected from the community. A different perspective of this issue was raised by an M & E Officer in the 'professional relationships' section above.

.'And then we are faced with confrontations from people. Different communities they have their own way of doing things, so you have to be yourself, what I mean, to take things as they come, otherwise, somebody who is very hot tempered, you'll hardly be successful in doing medical profession' (Male, Bonthe, IDI-3)

'..... well this monitoring, this community involvement ..[..]... I want it to be minimised because they are not here to police us especially these monitors because sometimes they just act as policemen policing us all around the place, you see sometimes it is more demotivating because they are just handpicked from the streets and we are professionals and they want to supervise us, how can you supervise a professional if you are just handpicked from the street so I think they have to restructure the monitoring so that we work as a team, not just to police us. We should work as together, because sometimes it is so demotivating, giving negative reports about the job it is very demotivating when you can just compliment ourselves; we want them to monitor us but they should not police us we should work together as a team...' (Female, Kenema, IDI-9)

One health worker was demotivated by a situation wherein he needed the community to play a significant role in the development of health facilities' infrastructure. He felt that sensitisation was needed in order the get communities involved in the development in terms of infrastructure and effectiveness of health facilities.

'Well the community participation was very very poor. Like at one time MALIN built a covered roof for the patient to wait, it was covered with tarpaulin, the tarpaulins were damaged and all the sticks were rotten because of the rain. I ask the community people to help to renovate that one, they did nothing. I had to do everything by myself to actually reroof that end...[...].I think more work should be done in preparing our communities in trying to work with people' **(Male, Kenema, IDI-4)**

Another misconception by the community as regards to the financial status of health workers; some health workers had payments delayed finances and relied on the community to help. With these misconceptions, opportunities are missed to help health workers.

'However there are a lot of challenges with the job most especially like the time I was in the community, the perception about the health staff, by some communities, that we well taken care of by government and which is not the case was sometimes discouraging; because even when you needed assistance from people within the community they thought you have everything, you are OK financially' **(Male, Kenema, IDI-5)**

Another health worker in a rural posting felt that people within the community do not value their health and the role health workers play, by not paying for health care services even though they have the means to do so.

'What I don't specifically like is that people that you expect should pay, they don't pay for their health, they have the means to pay but they just take it that the health profession is just like any other thing anybody can just get into it; that's what I hate about people' you should value your health, you should pay for your health if you have the means to but people don't pay at all' **(Male, Koinadugu, IDI-11)**

Separation from family

Of the health workers in rural posts included in this study, 6 (4 of whom were female) voiced separation from their families as a demotivating factor. In the families of the female respondents, husbands had to assume the role of both father and mother. As the opportunities to visit their families were limited, children were growing up without much of their mother's presence in their lives; in essence they had become strangers.

'I have already told you some of the challenges especially me not staying with my family' **(Female, Bonthe, IDI-1)**

'Whenever you have to travel you have to go by commercial vehicle and that one is risky, leaving your family back home, being in the provinces so long, you are away from your family it has created some sort of social isolation and stress. Any way it is too much' **(Female, Koinadugu, IDI-9)**

'.....the distance is far from my family, my family is in Freetown. I have even a little girl who will be four in this month. I left her at one year plus. So it's like saying I miss them a lot, they are growing without me; and most of the time they are calling me on phone for emergencies pertaining to the family; I have to jump into vehicle and go. And we don't have vehicles, road worthy vehicles that you can always take to go, and if the vehicle is available the fuel cannot be available. As such I always, almost always using public transport to go and come, even for the work we don't go out all the time as I have said earlier because of the transportation issue. So that is making it a little bit difficult [.....]

and my husband is complaining because he cannot come. He is like the mother and father so that is the problem' (Female, Koinadugu, IDI-8)

Communication in the hard to reach areas of Sierra Leone is poor and with the limited opportunities to visit home, it makes it difficult for separated families to stay in touch.

Insecurity

Insecurity was also a demotivating factor for 5 out of the 23 respondents. Personal security issues were experienced predominately by those working in hard to reach areas of Sierra Leone and having to use dangerous means of transportation. To travel to Freetown to see her family, a female health worker had to travel at a very late hour to use the infrequent commercial transport available and other unsuitable means of transportation. She reported that a female colleague had lost her life by using the same means of transportation.

'And even we the Sisters I don't know for others but for me I don't think there is much priority. Just imagine if I want to go to Freetown, I have to go out and use commercial vehicle. Like here if you don't get up by 12/1am you will not get a vehicle to go to Freetown [...]...and I have no alternative unless I decide to take a motor cycle. At my age on a motor cycle I don't think it is appropriate.[...].... Did you hear about the death of our colleagues? If that lady had a vehicle or a vehicle was available for her to use within the DHMT, I don't think she would have risked her life using a commercial vehicle. We stand to be corrected but we really need you to think about us (health sisters) in the provinces' (Female, Bonthé, IDI-1)

Others issues of personal safety were experienced during the war which will be discussed in the 'Context of conflict' section below.

Tensions in the workplace

A number of other factors were cited which caused demotivation in the workplace, such as lack of punctuality by colleagues, absenteeism, lack of respect for roles, and resentment of each other's role within a team. All of these can have knock-on effects on workload, teamwork and satisfaction.

'.....so I went there to challenge the problem of indiscipline....problem of attendance yeah.... among staff problem with indiscipline problem with attendance...[...].... so I went there and did my own little bit make sure I change the staffs because by then in fact even going to work people are not properly dressed.' (Male, Western Area, IDI-18)

One health worker was particularly demotivated by colleagues not working within their professional remit and not sticking to their job descriptions. For example, matrons are not given a free hand to manage the hospitals and doctors interfere in the affairs of nurses.

'.....the challenge of, well being Matron even is a challenge because formally I would say the hospital is the Matron's and mostly you are given a free hand to work but nowadays it is a big challenge. Sometimes you want to take decisions you cannot, because when you can take the decisions people raise brows..[...]..For instance with the roosters in our days you dare not tell a Matron where you want to work or when you want to work there but nowadays people are bold enough they will go to the office Matron...[...]....In that case I will not change that person and some doctors will come and

say 'Matron good morning that nurse I wanted to work with she did not start' ..[...]. So that is a big challenge people want you to do what they want and sometimes it is not what you want..' (Female, Western Area, IDI-14)

One health worker shed some useful insight into the hierarchal structures within some health facilities that needs to be improved. In some health facilities, SECHNs are in charge of supervising other equally qualified and sometimes more experienced SECHNs, which has a direct negative impact on the management of health facilities. In addition it was recommended that night supervisors should be reintroduced to help improve the service delivery in health facilities.

'And then you walk in to the ward situation an SECHN in charge. So I think you just kind of neutralize power, so it means there is not much control because when one SECHN"s tells the other SECHN what to do this one will say am senior for you in the service but then when you look at the status they are one and the same. So you find because of these gaps in the hierarchy there was not much control' (Male, Kenema, IDI-6)

Lower cadre staffs have to take on roles they are not qualified to perform unsupervised, which fuels the indiscipline amongst staff. There was one reported case of newly posted health workers experiencing hostility from health workers already working in the health facilities. It was perceived that this was due to the existing health workers feeling threatened by the new recruits in terms of job promotion.

'..... well the other group of people.....they are fussy, but they think they are also taught and so they should not refer patients are the MCH Aides. We have some of them who are still stubborn they think they can manage every case, in fact one of them told me, 'Matron some of the cases that we handle, even the hospital will handle them with caution (or are afraid to handle them)' (Female, Western Area, IDI-14)

Another health professional reported experiencing challenges whilst working as an M & E Officer, as the other health workers thought he could be a whistle blower.

'....the idea of M&E was looked at something very negative, perceived negatively, by even the team members of the DHMT and some other people outside the DHMT....They didn't really know what M&E work is all about, people saw M&E like people coming to investigate them, police them, so we kind of asked people for information sometimes they were always very sceptical, sometimes reluctant to provide you with information....Because they have not been used to the system, there was no better monitoring system in place in the past.They saw this as a new concept even though it was not new, it has been in existence but it has somehow dormant within the system so when it was activated people kind of frowned at it. But for the past few years we have been there, though things have not totally change but I think people are now reckoning with us. They have started seeing the reason because they have seen that there is no way they can do without the M&E work. So even though there still few challenges sometimes people do not want to give full report on their activity, people do not want you to know about what they are doing in depth but to some extent they are now responding well and I mean accepting us'. (Male, Kenema, IDI-5)

Poor retention of staff

High attrition of human resource in the health sector was reported as a demotivating factor. Health workers in this study felt that the government should also do more to address the high attrition of staff in the health sectors and put into effect measures in place to retain trained health workers, which in effect will deal with the low staff numbers and address the lack of human resources in some health facilities. A direct consequence of this is that less experienced members of staff are assuming roles that require more experience on the job.

'because I mean if the health system has to improve I believe these are the challenges the Ministry of Health and Sanitation must address right and if they are to retain staff right they have to address these things and it is not a matter of the long run they should be thinking about it now right; if they should retain staff because a lot of colleagues who are very competent are leaving the ministry, those that are experienced, are leaving the ministry right and the government is recruiting just those from the university while the trained and experienced ones are leaving the ministry so it is, it is not helping the ministry at all' (Male, Koinadugu, IDI-16)

'.....yes the attrition of medical doctors and nursing staff those days; you find the most junior nurse that you find who man the ward is a staff nurse..[.]....I don't think if we have up to 3 senior nursing sisters and staff nurses are few; state enrolled M&E community health nurse that never used to be in charge of the wards are now in charge of some of our wards. Among the doctors as I said earlier we used to have SMOs, Senior Medical Officers but we don't have anymore' (Male, Western Area, IDI-17)

Long working hours

There is a running theme of health workers being posted to the provinces to assume leadership roles and finding that the health facilities are understaffed. One health worker posted in a supervisory role reported more volunteers or untrained staff compared to trained staff at the health facility, and to ensure that the right care is provided to the service users, she has to work at night to offer additional technical assistance and supervise the untrained staff.

'..... for instance in Mabugurka I wouldn't mind people knocking at my door at night because maybe people who are on night duty have only maybe one midwife and some cases she would not be able to cope and she cannot leave the volunteers to do anything because they are dangerous'(Female, Western Area, IDI-14)

It is a common occurrence for newly recruited staff posted to these difficult terrains to not report for duty, which increases the workload of health workers already in post, especially those in supervisory roles.

'I don't have time for my own social activities, it's another big problem. Social activity, I don't have time, maybe at times I will be preparing for church service and then they will call me 'please come'most of the time I will be in service they will call me, 'please come'. So it's another challenge due to staffing, short staff. And most....another challenge, to prepare food for myself, I will take three days trying to cook a sauce, because as soon as I prepare the pepper and onions they will said please come, I will leave it..... I have to remove everything from the fire, maybe the time I will be returning it will be late in the night, I will not be able. Early in the morning maybe by 5 or 6 they will wake me again 'Please come' (Female, Koinadugu, IDI-10)

‘..... During that same year I lost two of my sisters elder sisters .One died six months later another one died. I was never able to attend neither the funeral nor the fortieth day ceremonies because of such things...[...].....So this is how sometimes this job keeps you from your commitment...’ (Male, Kenema, IDI-6)

Recruitment process

A number of the respondents expressed dissatisfaction with the recruitment process into the health sector. The recruitment process was described as not straight forward, with senior level cadres who have to work with the recruited staff not being involved in the recruitment process. One respondent had to offer a bribe to fast track his Public Service Commission (PSC) application.

‘..... let me start first the recruitment process because we are not responsible for training and recruiting some of the nurses and even the health workers so that is a problem because since we are not recruiting and we are not doing the postings we have a lot of challenges because now these nurses when they are posted in the hospitals they don't really report for duty so as the Matron even taking care of the hospitals sometimes it's a problem like, like for instance in budget if we are involved in the initial preparation of budgets but the final drafts and even sometimes the implementation is a problem so as the Matron these are some of the problems. Even some of the cleaning of the hospital for instance in some hospitals it was devolved, I mean it was contracted to some of these cleaning agency and the Matron and even the medical superintendent even some of the hospital management is not directly involved in some of this activity so see those are some of the problems’ (Female, Koinadugu, IDI-9)

‘I made the application.....the forms were there for over a year; I am sorry but what I am telling you is a reality. Then somebody told me if you are going to leave this form there then I will not be employed. I came about once or twice and when you come down in Freetown I was determined I should be interviewed. In 2007 I was determined that I must be interviewed.....I had to bribe 300,000 Leones so that I could get an interview with the PSC’ (Male, Koinadugu, IDI-12)

Challenges of rural postings

Health workers working in different parts of Sierra Leone are faced with different challenges. Some challenges are similar in urban and rural areas, for example the increased workload after the implementation of the FHCI. Others are unique to particular areas, for example crossing the Shebro River to get across the riverine area in Bonthe and the difficult terrain in Koinadugu.

Health workers based in the hard to reach areas are faced with a number of constraints in the job, such as difficult terrain, bad roads, poor communication, delayed allowances or no allowances, whilst having to deal with an additional emotional burden of being separated from their families.

‘The place is very hard to reach, the road network is very poor, the communication as far as it is concerned to get contact with my family is very poor, I find it very difficult, in the job as far as finance is concern is not encouraging’ (Male, Koinadugu, IDI-11)

‘To start with I am not staying with my family here. In fact my children are now almost strangers to me and I am a stranger to them.....I cannot go spend even a week with them. The highest time I can get off work is just one or two days just to go and see them. Even if I want to go and see my family I have to use commercial vehicle.As I have already mentioned I want to see my family once in

a while. At least alternate months I should be able to see my family. I have to get a commercial vehicle just to see my family. Even on the journey back I have to use a commercial vehicle. There are no allowances for these things. We are here and we are doing the job' (Female, Bonthe, IDI-1)

Health facilities in these hard to reach areas are understaffed, meaning additional work burden for the health workers who are compelled to work hard to help reduce mortality.

'Like I say this mass migration of our trained nurses, but I believe that even after the war with the developmental strides that has taken place this hospital has improved tremendously. There is a shortage of midwives; you need more midwives per number of patients and we need more of them but even though they are training to me, like the Midwifery school is too small now for them. They need a bigger institutions so that they can train more midwives that would stay in midwifery and not having people who are SRN, SCM maybe in a few months' time your midwife that you may have trained in certain areas is taken away and sent elsewhere; and perhaps where she goes, she's not even going to practice midwifery; because she is a registered nurse she can go and work as an administrator in a general hospital. So you find out the time spent training people is wasted'. (Female, Western Area, IDI-23)

One respondent working in the riverine area described the challenges they have to face transporting patients using difficult and dangerous means, using public transportation as the facilities do not have a boat of their own. Hospitals in these areas are usually without doctors so patients are transported over very long distances at sea, which sometimes involved having to travel 2 days at sea.

..... if they call for a patient, a referral, I have to go and see that patient, come with the patient because we don't have enough staff. In fact let me hasten to tell you this, the whole of Bonthe district, we just have one midwife at the island, the matron, we have 5 demobilisation centres, we have just two midwives. And according to the policy all those demobilisation centres should have a midwife. We don't have midwives.....extra work, extra burden.....we are talking about maternal reduction, not so. So we will put hands together so that we can reduce the maternal deaths.....we have the mainland and the riverine and this area is the riverine.if there is a refer case let's say like in Denkah, Dema, they use those small boats (bora canoe boats)..... You take that patient, at times two days at the sea, bring that patient to Yawei or Bonthe. If it is at Yawei we go for that case, we take that case to Serabu or Gendema if there is no doctor. In fact presently there is no doctors at the UBC hospital.....So those are the challenges. We don't have a boat of our own. These are some of the challenges. So please with this interview we want you to remember us. We are here and need your backing. So that we can see people behind us please' (Female Bonthe, IDI-1)

Others reported having no choice but to resort to using motor bikes on very bad roads, with the journey being even more dangerous during the rains. In such situations, health workers think being provided with travel allowances will motivate them as they have to sacrifice their social and personal time being called upon to work around the clock, meaning work commitments come in the way of family commitments. In the provinces, health workers stay in very close proximity to the health facilities and are therefore expected to work around the clock.

'Bama was also a hard to reach community because you have to ride so many distance on motor bike and then you have to cross a river. It was so risky that in these narrow boats you have too much people loaded onto it and sometimes they have to load the motorbikes, because they were using the

canoes to cross the motorbikes as well. So it was very risky especially in the rains, the water burst banks and then you have the high level water, and sometimes people use paddles to row them, you go upstream and then you try to cross from upstream and sometimes you are driftedIt was a very risky business. And even after that point there was no good road condition going to Bama Konta. There were so many rivers along because they were not paved, there was no bridges, no culverts, so you have to ride through rivers to get to the point. Sometimes when it is heavily raining you cannot move anywhere because those rivers over flows and even vehicles and motor bikes cannot make it through. So I was there...'. **(Male, Kenema, IDI-4)**

Posting policy states that duration of rural postings should be two years. One health worker reported that she has been in her current rural posting for eight years. However, there are health workers who have negated the rural posting process due to political interference. There are also others who have defaulted from their rural postings without any disciplinary action. This is a demotivating factor for those that stay in post. The transition to working in rural areas is not smooth; accommodation is lacking and in some cases good schools to continue with their children's education are not available.

'..... because actually I didn't want to come in the first place because I wanted to go closer to my family for few more year, because we are supposed to work for at least two years in the province. I have done eight and even when I did six I wanted to go to Freetown but I was not given that opportunity..[...].....So I stayed and am still staying and I don't think I will request again for another posting, maybe next time I will request for leave not posting' **(Female, Koinadugu, IDI-8)**

The posting procedure was also a dissatisfactory factor for health workers. One health worker felt it was necessary to revise the posting policy; according to the posting policy, health workers are posted to a station for duration of two years and then rotated. In this case the health worker had been working at the same station for ten years, with no fringe benefit. This made her feel isolated, inferior compared to her colleagues and forgotten by central government.

'Because I have stayed longer up the provinces because there was a policy that you should just stay for two terms, but now, it has been long overdue. I have stayed for 10years you see. It was only by God's grace. Most of my colleagues they are up there today (as in have made good progress up the career ladder), although I cannot say I am left out, but I thank God for keeping me in my present job...[...].....They should know what our strengths, our weakness, our opportunities and threats; but nobody cares. Even from the Ministry...[...].it's only nowadays that I am seeing people coming up; before when we were there it will be a month or two before you see....or even after 6 months; nobody cares, whether you are well or you are sick, nobody cares.....' **(Female, Kenema, IDI-9)**

Another health worker felt that the rotation of health workers should be revisited as it could potentially create the ideal platform to bridge cultural and regional gaps.

'I want to do more but then let emphasize this rotation as a national service, whether you coming from Aberdeen, come and work in Bo, whether you coming from Bo go and work at Lumley for a while so that you change your environment...[...]......So that people will change their way of thinking. ...[...].and then they should understand that the laws in this country are general for everybody so that but when we interchange regions and then we begin to understand' **(Male, Kenema, IDI-6)**

Coping strategies

Religion, patriotism and improvising have served as coping mechanisms for a number of the demotivating factors encountered by health workers in their professional careers.

'Praise be to God. With those challenges, but we can still say thanks be to God for His mercy. Because it's only by the grace of God for me...Well, in all instances we have to Praise God [...]But we don't mind, we know that one day our Lord will see us through... But we hope and pray that they will remember us one day.[...]I just have to cope. I have nothing else to do. I pray that things will change' (Female, Bonthe, IDI-1)

The donor community has also been helpful in providing incentives for those who for one reason or the other are not on Government salary. The communities have also assisted some health workers by providing food, for instance, or assisting in securing accommodation for health workers posted to locations away from their normal place of abode. Others have engaged in petty trading and other activities to increase their monthly income. Health workers have had to learn how to be diplomatic in dealing with hostile colleagues.

'....at that time we had a NGO, MERLIN that was supporting health services within the district so they were providing some incentives for us as staff' (Male, Bonthe, IDI-5)

'.... it was very, very difficult, firstly, firstly you have to take care of your family, remember, as I already mentioned I had to take care of my family... I was living on no salaries, except once in a while the community looks at me because of the way I mingle with the community they assist me but there was no salaries...they were assisting me giving us food' (Male, Koinadugu, IDI-12)

'we have this system of improvising, we have to improvise to make sure that work goes on because we cannot say because materials are not there we cannot work and that is why we're here. When once you have come to work you should make sure you do something so we started improvising..... as I say it's the work of humanity and I have a fear of the Almighty God it's my country I love my country this is the way I am demonstrated my own patriotism by giving service to my people...managing it's not easy but I've no alternative but it's not easy for a family man like me I have a wife, I have children so you can imagine how much it will cost. The mere salary I am given at the end of the month..... No provision for staffs ' (Male, Western Area, IDI-18)

'And some people started selling drug those who have access to drug like paracetamol. I know one of my colleague who was selling paracetamol not even in the hospital but after work [...]....but me I used to sell jewellery' (Female, Western Area, IDI-18)

7. Changing context

Here we explore how health workers experienced changes over time – before, during and after the war – both in terms of their personal experiences and also their views of the changing health system. The conflict period in Sierra Leone varied from one health worker to the next as different parts of Sierra Leone were affected by the war at different times.

Pre-conflict period

The health system

It was reported that health worker salaries were low in general, accompanied by low levels of health worker commitment. In addition it was reported that the equipment provided were misused and support from central Government was lacking. These were all contributing factors to the disorganised health system that was in place during the pre-conflict period, as described by some health workers working in some rural areas.

'Well before the war things were done in a very disorganized way....[...]....like documentations, judicious using of drugs and other materials that are available to you, support for you to do your work was hard coming in' (Male, Kenema, IDI-4)

This recount may well be describing the situation just before the war as other reports (see below) were more positive. Connaught hospital in Freetown in the 1970s was described in a more positive light. A health worker recalled that during her student days there were a stable electricity supply, water supply and good infrastructure within the hospital that resulted in the health care delivery service being effective and efficient. Night and day superintendents were in post and tasked with ensuring that the hospital was run smoothly. Another health worker recalled that doctors in the pre-conflict period worked efficiently and effectively with an admirable level of dedication to the service. Health facilities were described as having sufficient human resources and the affairs of the health facilities were governed by health workers with no political interference and discipline amongst staff.

'We had enough logistics to work with...[...]....And we had a specialist, a decent group of gentlemen at that time; even the younger ones, medical officers, registrars, they were dedicated, dedicated enough for just one phone call and they are here. You can see a specialist being called at 1am and he comes here in his dinner suit, you know what that meant. He was at a dinner party or something and he was called; and I'm sure he leaves his wife there for someone to take home. But he came; and when you work with people like that, I mean, who are you to mess around?' (Female, Western Area, IDI-23)

'..... it was very interesting because there was a lot of discipline and then the hierarchy was there. ..[...]....and then you had night superintendents, day superintendents and ...[...].... there was a lot of respect and people were more or less dedicated and committed to their work. (Male, Kenema, IDI-6)

'In those days there was nobody that was connected to you; whether you are a student, whether you like it or not you follow the rules whether you like it or not. In the rules either you shape up or you ship out. Because if you want to become a nurse you follow the policies, because nobody will intervene' (Female, Kenema, IDI-9)

One health worker recalled that the clinical side was not doing well compared to the public health side because the clinicians were not being trained. Hospitals were described as comfortable as adequate housekeeping and drugs were available, making the health delivery system 'much better. Another health worker described the health system then as 'quality service was available for those who can afford'.

'... well before the war the health sector was, was dichotomist; you had clinical side and you had the primary health care side or the public health side. Before the war the public health side was doing quite well, but the clinical aspect was completely neglected, they were not training clinician's and that is what's affecting us now..[...]....some of us that trained got there on our own we are aging and training should be a continuous process so that as the old leave the others will fill in our place and you always have a middle, a manpower in between. But here it doesn't exist, after me it's my house officer; in a proper system after me there should be registrars, senior registrar, registrars, SHO' (Male, Western Area, IDI-17)

'Before the war, there were quality service but for people who can afford, because we had good hospitals in the country by then, you talk of the Mission hospital, you talk of Mabasengne Hospital, you talk of Serabu, Mattru Jong, these were Mission hospitals complimenting the efforts of Government in bringing out good health care delivery services in the country, but some were also as humanitarian organisation they were that much not strict on monetary affairs or whatever, so people were coming from various parts of the country to come for health services in the institutions' (Male, Western Area, IDI-21)

One health worker reported a form of free health care in the 1960s, which implies that health care delivery system was fully effective and effective during that period. This is contradictory to the quote above, probably because both health workers are referring to different periods under the 'before the war' umbrella.

'I don't know maybe when we are kids we used to go to hospital in our uniforms and we don't pay anything. I don't know, we were very young maybe at the age of 5 years and in 1962; also I don't know whether it applied to other people but I remember your teacher write a note for you to go to the hospital..[...]....maybe that was another form of free healthcare' (Male, Western Area, IDI-17)

Situation of health workers

Varied but limited responses were recorded with regards to the training for health workers in the pre-conflict period. A rural health worker recalled no training opportunities before the conflict, whilst a health worker station in Freetown recalled being in a motivating learning environment. There was also support for health workers working in Freetown in the form of incentives from NGOs such as Medecins Sans Frontieres (MSF) and additional support in dealing with emergencies effectively. This created an encouraging working environment and an ideal platform for knowledge transfer.

'...They are the same [i.e. referring to the challenges before the war]. In every field you find yourself there should be opportunities allowing you to grow in the system..[...]...Grow in the system means you should be given the opportunity to acquire more knowledge' (Male, Bonthé, IDI-2)

'.....before the war I learnt so much from people ..[...].... they were willing to teach us and even when you want to stay home, you just rush to the hospital because you are always ready to work because at that time we improvised. If there is nothing to work with, you improvise and then people like MSF were here and then also Cap Anamur were here..[...]...they encourage us....[...]...they gave us incentive' (Female, Western Area, IDI-13)

Health workers recalled discipline, hierarchy and respect as being there amongst health workers in the pre-conflict period. Salaries were described as low by one health worker and as favourable but not appreciated by another.

'....well yes, discipline for one; in our days the if you are a trained nurse and you see a staff nurse coming you would stand up to say good morning or good afternoon and see that what she wants is being done' (Female, Western Area, IDI-14)

A number of health workers also reported not being on salary in the initial phase of their employment. One described not being on the payroll for over a ten year period and his main source of income then was from cost recovery and money earned from attending workshops.

'One striking thing was when I graduated in 1991, I wasn't on pay role until 2002...[...]...By then we had cost recovery, which is what I used to survive on. I also earned an income from workshops.' (Male, Bonthé, IDI-2)

The conflict period

The health system

As expected, the health system was described as being terrible and hospitals were described as not properly functioning during the conflict period. Sierra Leone was in a state of anarchy and with no security in the health facilities and with no support from the Government, many health workers sought refuge elsewhere. Therefore the health facilities were understaffed, staff left Government run health facilities to work in private health facilities and in some cases government facilities were left unattended whilst others shutdown.

'It was terrible..[...]....During the war, I had to go to my village for four months..[...]....The tension was too much in Freetown. It wasn't even safe to look out of the window. I had to go to my village. It wasn't easy. I wanted to survive, everyone was running for survival. I wasn't in Freetown at that time. After the death of our Principal (at the nursing school) I saw her corpse and after seeing that I decided to run to my village for safety. All what we heard about the health sector wasn't good news..[...]....Because you can have people say most of the doctors left the country not to mention the nurses. So in a situation like that, how can the health sector at that time be good? It was very poor. Most people lost their lives due to lack of access to medical facilities. So one cannot compare the health sector then and now. You and I know what happened during the war. I had to take refuge in my village. I didn't want to die.' (Female, Bonthé, IDI-1)

'it was not good it was not really good because at that time the salaries were low and not all nurses come in on duty because most of them were afraid so a lot of them travelled for safety. It was not good it was poor, patients were coming but we had less staff and they were underpaid. So most of them were working at the private hospitals' (Female, Western Area, IDI-16)

'....the little resources they had, I mean human resource even physical resource just disappeared because doctors left and they never came back, ME nurses, anaesthetist, and pharmacists, they left and many of them did not return'.(Male, Western Area, IDI-17)

Infrastructure was greatly destroyed during the war and some health facilities were run in temporary structures.

‘...for us working in the provinces it was terrible because of the rebel war the hospitals were burnt down, there was no housing, erm infrastructure was a problem even the salaries was a problem so those are some of the major events’ (Female, Koinadugu, IDI-9)

‘Infrastructure was not too good. This rehabilitation that we have here now was needed long time ago; ok it’s never too late. But at that time the infrastructure was not good really’ (Female, Western Area, IDI-23)

It was reported in some places that the staff drainage meant nursing aides were running hospitals.

‘Let me just say Sierra Leone was in a state of anarchy...[...]...There are some places they actually closed down, there was nobody. You can even have a nursing aide manning the affairs of a whole hospital....[...]....during the war people cannot pay the cost for service so they were not using the facility’.(Female, Koinadugu, IDI-9)

Hospitals served as refugee centres which created hostile and sometimes confrontational environments. Drugs were in short supply and the added burden of refugees needing drugs amongst other things, created a challenging working environment for the health workers. In functioning displacement camps, free health care was provided with help from NGOs, as service users could not afford to pay for health services during the war. They also experienced the additional burden of lack of infection control and overcrowding.

‘.....some of these hospitals were camps almost so during the war; for example when we managed to find our way into the hospitals, it was not only patients that we met there. People who are gone there to find refuge where also there..[...]... don’t know whether it was because of the effect of the war some of them would lash at you some would want to fight you as you try to get accommodation for patients ..[...]....it was difficult to get them out so that patients could lie on those beds; they thought we were very inhuman asking them; and even those who are not patients who were there needed food, they needed clothes, they needed medications; although it was available but it was not enough..[...]....so it was difficult during the war. (Female, Western Area, IDI-14)

‘...but there was no system together but with the help of these NGOs, MSF, Red Cross..[...]....they come on the ground and assisted and they were given and helping with materials medical supplies’ (Male, Western Area, IDI-18)

‘... but that was free health care that was what we were doing, because we were treating these vulnerable people free of cost, you know they were internally displaced people, you know in a town of about 27,000 people coming from various, all corners of this country in one place, so there was the health problem there in the camp was challenging, we have these diarrhoea cases, respiratory tract infections because of overcrowding’ (Male, Western Area, IDI-21)

One health worker recalled the health system as being ‘in a mess’ before the war with service users who were already poor. The war then fuelled the downward turn of the health system and the livelihoods of service users. Another health worker described being trapped in the hospital; patients were not getting the right level of care, resulting in death in many cases.

'.....I am quite sure even before the war Sierra Leone was in a very deplorable condition even the health system, because even before the war the whole country was just under total mess completely...[...].this is just like putting fire on petrol or petrol on fire [...] So it was actually consequence not only on health but everywhere, war is not a good thing [...] people are already poor then you go and start killing them.' **(Male, Western Area, IDI-17)**

Situation of health workers

A number of health workers' initial training was affected by the war. Health workers were prime targets for kidnapping by the rebels. One respondent was unfortunately captured by the RUF rebels during the conflict period and had to endure working as a health worker behind rebel lines.

'.... I was abducted by rebels in 1993. I was with the rebels up to 1995, and when I gained my freedom ...[...].It wasn't an easy task; being in captivity means not being able to do things your way...[...].They [referring to the rebels] always wanted to do things their way and not professionally. They will come with drugs and want to administer them when and how they wanted to and not in the way it should be administered' **(Male, Bonthe, IDI-2)**

Another health worker described not wearing her uniform to avoid being identified as a health worker. Thus the once symbol of pride no longer served that purpose.

'.....during the war I had to stay home really then after some time I came back and then there was a time I was really afraid to use my uniform' **(Female, Western Area, IDI-13)**

Health workers lost members of their families and colleagues during the war. The conflict also had a negative impact on the human resources available for health as a number of key health workers left the country or their postings to seek refuge elsewhere. Health workers were afraid to go into work, meaning that the health facilities were understaffed.

'Hearing about people being maimed, people being killed. In fact my mother was also brutally killed by rebels...[...].the thought alone scares me sometimes' **(Male, Bonthe, IDI-3)**

'After the death of our Principal (at the nursing school) I saw her corpse and after seeing that I decided to run to my village for safety. All what we heard about the health sector wasn't good news' **(Female, Bonthe, IDI-1)**

With the country at a standstill, salaries of health workers were severely delayed and health workers had to improvise and ration food portions to survive.

'.....really it was we lived by magic because even you cannot you don't know when you will get your salary and what you have at home you don't want it to get finished because there are children round...[...]. So we had to manage the finances we even had to manage the little we had..[...].people who had the stuff will hide it because they don't want it to get finished and you wanted you are searching all over the place. Even one of our church members lost his life just going out to look for rice and he was shot...[...].For me in fact I was drinking ORS, I hated ORS all my life....' **(Female, Western Area, IDI-14)**

Some health workers stationed at refugee and government clinics were receiving incentives from MERLIN and MSF. With health facilities understaffed, health workers were faced with increased

workloads. Mobility was also a challenge. Health facilities in the provinces usually serve as accommodation for health workers; with health facilities burnt down in the war, some health workers were displaced from their normal abode. In addition, working in the health facilities also meant putting their lives at risk with no medical insurance to fall back on.

‘During the war, the security checks in my work station was challenging, also initially when I went to the PHU I had problem with mobility. In fact there was a time I had to ride bike facility from my health facility to Kenema, accommodation was also a big challenge at that time. I did not have quarter, I was housed in the same quarter I was using as clinic and for quite.... [...]...Also in the PHU the work load was too much the staff capacity was very low like we were only, initially we were only 3 myself the CHO, one SECHN and one MCH aid so we were kind like subjected to work right round the clock...[...].... and there were no extra enumeration for that, we had no incentive for overtime. And again working as a health worker one big challenge is that with all the risk that we are faced with in dealing with different kind of condition, there is no medical insurance for me as a health worker. If anything happens to me it has to be me and me alone, except if somebody from my family decides to assist me but there is no provision’. (Male, Kenema, IDI-5)

Some health workers also started off their careers in the health field as volunteers, not receiving any salary from the central Government. In one such case the health worker not only had to work without salary from the Government, but also had to additional burden of working in a hostile working environment during the conflict.

‘It was somehow challenging because I was not on government salary. I went as a volunteer and it was during the war, the war was still on and it was partially deserted community with armed men all over the place. We had the civil defence Militia, and we have the ECOMOG [Economic Community of West African States Monitoring Group] troops that came to assist with the war, so we were always on our guard during that time because there used to be attacks all over the places so it was actually somehow challenging at that time. (Male, Kenema, IDI-5)

Health workers coped by staying positive and were motivated by the incentives received from NGOs.

The post-conflict period

The health system

The post conflict period can be divided into different phases. In the period immediately after the war, there was a breakdown in the structure of health care delivery systems. One health worker stated that ‘the whole system catapulted’ as a direct consequence of the war. Situations were described wherein patients were asked to buy gloves, delayed the treatment process. Many patients were extremely poor after the war and could not afford to pay for hospital visits; doctors were known to treat patients free of cost and nurses bought drugs for patients who could not afford to otherwise.

‘...things are lacking. You can imagine coming to a government hospital like this, you have to write a prescription for a patient to buy a box of gloves. You see time is not of the essence because a patient come you have to give prescription what and what to get, so it's time consuming they have to go get these things come, so you know it frustrates you. These things should be there, a patient come you just go in set yourself immediately so it's frustrating quite unlike before. Before in the wards we have

the medicine cupboard, we have different cupboards where we keep things consumables like cotton wool, gloves, antiseptics.....' (Male, Western Area, IDI-18)

'.....people were very poor, poor to the extent that they come they didn't even have money to buy drugs. In those days you have to pay money, they don't have money to pay consultation fees they don't have money to do lab tests, they don't have money to buy drugs, sometimes you have to give your own money to them. So a lot of people were coming here I mean it was a big challenge, what do you do. You use your money or you let this child die something I mean most of the time in the end you have to use your own money, spend your own money because the moment you see somebody you know this person if you don't help this person he's not going to survive definitely so those were challenges' (Male, Western Area, IDI-19)

Working conditions in health facilities were challenging and some health facilities were supported by NGOs, philanthropic sources and also religious organisations.

'... its improved after the war because we had NGOs coming in...[...].after the war I was at Children's Hospital there were a lot of families who brought food items, clothing and it the hospital ...[...].we had people from overseas who brought things ..[...].we had a from Muslim agencies also, so they doing that after the war there were even before the free health we had a lot of help from outside within and under individuals even from nurses; people were then I think that the war brought the sympathy and so many people brought things that could save lives or help people develop' (Female, Western Area, IDI-14)

Health facilities were also receiving continued support from some NGOs; for example Cap Anamur and UNFPA, especially in support of the FHCI. Health facilities were lacking the vital human resources as very few health workers who left during the war returned. This caused a change in the working dynamics in some health facilities.

'Like I say this mass migration of our trained nurses, but I believe that even after the war with the developmental strides that has taken place this hospital has improved tremendously. There is a shortage of midwives; you need more midwives per number of patients and we need more of them but even though they are training to me, like the midwifery school is too small now for them. They need a bigger institutions so that they can train more midwives that would stay in midwifery and not having people who are SRN, SCM maybe in a few months' time your midwife that you may have trained in certain areas is taken away and sent elsewhere' (Female, Western Area, IDI-23)

'for Children's Hospital they say they had and NGO Cap Anamur they brought a lot of these I think it was pulse oxymeter, oxygen concentrator, so which made work easier; because before if there is a child that needs oxygen we had to take the child from Children's to PCMH theatre if there is oxygen or put that child in an ambulance and go to Connaught Hospital which by then the child must have died on the way, so for us having that after the war they brought a lot of this..[...].So a lot of equipment that were brought to help the hospital and drugs that one made it more reasonable for us and the working conditions better than before' (Female, Western Area, IDI-14)

Another health worker felt that some of the demotivating factors that were affecting the working conditions in the health facilities have partly been addressed in the post conflict period. He also reported an improvement in record keeping in health facilities in the post conflict situation.

'Well part of these problems have been addressed...[...]. Well not fully addressed, like accommodations in certain places. Some equipment, materials are being supplied that you are able to work, manage to work; like for us in Kenema although we still have some problems but communication gadget were given out, mobile phones...[...]. and even VHF radios were given out by some NGO's like IRC in order to support their outreach emergency care. And there is also continued support from some NGO's like the IRC basically. We are having a better salary as compared to before. The introduction of the free health care changed a lot for the services delivered at the center...[...]. You have more people utilizing the facility at their disposal. And in this way you are able to help a lot of people because if there are drugs and other things, saving the lives every day is worthwhile...[...]. And some NGO's supported us with mobility, like UNFPA provided us with motor bikes...[...]. I think this should happen for every health worker especially those working out in distance locations; it's very useful. And also what has changed is the documentation aspect of the work, now we are able to keep a good amount of records on the services that we are providing, so at least there is an opportunity to figure out the way things are working now unlike before'. **(Male, Kenema, IDI-4)**

Some also commented on decentralisation, which has improved fund flows at a facility level.

'.....yes the decentralisation is one of the major events because before now we have to access all the funds from Freetown, but now we have the secondary and primary healthcare have been devolved to council and there is not much of a problem in accessing the funds because they we now access our funds directly from the local council. Although there are problems but it's even much more better because if the monies are available the funds are released by the central government to council they always take health as a priority'. **(Female, Koinadugu, IDI-9)**

Implementation of the FHCI had the most impact on the health care delivery system in the post conflict situation. One of the intended effects of the FHCI was to increase service utilisation amongst the vulnerable groups. This increase in the utilisation of the health facilities was experienced across Sierra Leone. Even before the FHCI, health facilities in some hard to reach areas were overburdened. Since the FHCI, health workers can provide services to more patients who otherwise would not be able to afford healthcare. The number of institutional deliveries has increased as traditional birth attendants (TBA) and service users have been sensitised on the importance of hospital deliveries.

'At that time, in 2002 there are four chiefdoms in the riverine area with a population of about 12000 and we only had only four health facilities, which was a heavy burden on the facilities then'. **(Male, Bonthe, IDI-2)**

'For the health facilities, people are now making use of the facilities even the maternal beds compared to before'. **(Female, Bonthe, IDI-1)**

Currently one of the tertiary hospitals is struggling to cope with the gap in mid-level doctors, as many have left to specialise as the health sector is lacking specialist clinicians. Only two senior doctors are currently in post and they are unable to supervise all the newly qualified junior house officers attached to this hospital. This situation translates into junior house officers dealing with the increased traffic of patients, mostly from the FHCI qualifying group, unsupervised. This issue should be addressed quickly to minimise the risk of increasing child and maternal mortality rates. Another health worker commented that the FHCI should have been planned better to ensure that there was

enough personnel who can work unsupervised and deal with the expected increased traffic of patients coming through the health facilities.

'...well after the war, there are have been some moves but the primary issue is still there unattended or they are being gradually attended and now they see the truth of it all. Today as we speak we have over 14 medical examiner (ME) doctors, distributed in East Africa and West Africa doing post graduate training what it is not something that you send in today and bring out tomorrow. It's a process that takes 3 years, 4 years, 5 years and this is a lesson that we must remember, that if we don't prepare, to prosper, to develop the health system we prepare to fail' (Male, Western Area, IDI-17)

'....so all of these people now we are putting at the forefront they take care of wards, they take care of children without even our supervision. These are house officers, we cannot supervise them because there is only two of us so when they come maybe they are with us one or two week and then they go out and then they go and take care of cases. So permanent doctors there are only two of us. We have one or two other doctors from the NGOs who come for help I mean but these are people they are not middle level workers they are people like us, consultants or so you cannot tell him to go and sit in the outpatients for a long time..[...]....but the problem the increase in the number of the attendance people seeking services but there is no increase in the number of doctors. I used to tell people you cannot manufacture doctors, it's not like drugs; we are making free healthcare we go and buy drugs from Germany or China we cannot go and buy doctors from Germany and bring them in but although it's good they have introduced this free healthcare it would have been better if they had planned before a long time ago to make sure we have enough personnel..[...]....but now the thing is we don't we don't even have the consultants who will help us train; I mean there are not enough so that's why the ministry told us they have been sending some of our doctors to the sub-region some have gone to Kenya some are in Nigeria and some are in Ghana' (Male, Western Area, IDI-19)

Health partners also have helped improve the sustainability of the FHCI by providing equipment/logistics (e.g. motor bikes for health facilities in hard to reach areas) to reach patients quickly and also help develop the infrastructure of health facilities.

'Now they rehabilitated some centres, constructed new ones. Presently like here a partner is constructed the BEmOC centres, they have also complete two of that; they provided ambulance for the primary health care for transportation of emergency of obstetrics cases; they also constructed the school, The Maternal Child Aid training School, they sometime support them in form of providing there materials they work with. A partner also paid the final year student fees the last time so we are getting there little by little' (Female, Koinadugu, IDI-8)

A rural health worker reported a drastic improvement at the primary health care level in the post conflict period, as a result of communities being sensitised on the importance of infection control, improved service delivery and an effective referral system.

'...for my own experience at the peripheral where we call we call here primary health care level primary health units, it is er improving drastically, not really slowly but fast..[...]....we are experiencing successes a lot of successes because the community people are now educated, being trained to teach people in the community what to do and what not to do so that they will not and what not to do so that they will not become sick. So this one is a big improvement in our work

because if people do not get sick then they will not come to the health facility and then we have less work...[...].and also to us at the health facility, patients are coming in straight now not in a severe condition and more staff are trained, they have developed their skills and took training so they can now give good or perfect health care services to the patients coming to the health facilities so there is improvement in the services that we give also because of the training' (Female, Western Area, IDI-20)

The situations of health workers

The most significant event for health workers in the post conflict period was the FHCI and its associated salary uplift. However, some health workers have had to engage in other activities to make money and augment their monthly income. With the increased numbers of FHCI patients, the workload for health workers has made it difficult to engage in other activities to make money. Health workers are therefore over stretched and it was evident in this study that most health workers in the rural areas, where human resources are sometimes lacking, have to work very long hours, which is not commensurate to the remuneration received. Some coped by practicing petty trading and with support from donor agencies (e.g. in Bonthe UNICEF provided boats).

'Well, as I told you, I am not staying with my family here. My family is at Freetown. So, I decided to do certain things that I can earn some money. I prepare soap so that they can sell them and get something (some money). Because the money I earn from nursing is not enough to share within the family..[.....]...in fact I am so engaged. We even work Saturdays and Sundays so we don't have the time. I have a lot to do with no time for an extra job. (Female, Bonthe, IDI-1)

'I wasn't easy as I was over-stretched working as a medical superintendent and also as a community health officer. I had to carry out primary health care duties like home visits and environmental sanitation. So it wasn't easy' (Male, Bonthe, IDI-2)

Health worker commitment in the post conflict period was questioned as some worked for both NGOs and government but were more committed to the NGOs, where remunerations were better.

'Well it was a bit better but today it seems as if structures are not yet put in place...[...].It seems as if we are creeping, now they are saying to monitor the attendance register, but I can tell you for free not all of them are committed. Some of them are not even coming to work. They are in NGOs; they ask their friend, their friends to sign for them' (Female, Kenema, IDI-9)

In the post conflict period one health worker reported being in receipt of leave and medical allowances, which are additional motivating factors. This was not captured in the other interviews. Comparing the pre and post conflict periods, there were vast differences in workplace discipline. In addition, political interference was experienced more in the post conflict period compared to the pre-conflict.

8. Source of income

Salaries

Of the 23 respondents that participated in this study, 22 reported that their salary was their most valuable source of income. The respondents described their salary as being dependable compared to

other sources of income, constant and regular (paid monthly compared to PBF which is quarterly). Their salary is the main source of income used to support their families as it is not based on performance as with PBF. There was also a sense of pride in working to earn a living.

'It is forthcoming. I depend on it every month that I will get my salary but all other allowances I cannot talk much about them' (Female, Bonthe, IDI-1)

'....my salary because I know it's forthcoming, because it's the most valuable for me and also because I know I am working for that' (Female, Koinadugu, IDI-9)

'..... I utilise my time and utilise my energy and I am rewarded for that it is valuable' (Male, Western Area, IDI-18)

'....It is a fixed price for me and as long as I am going to work every day..[...].... But with the PBF you really have to work for it before you get it, unlike the salary' (Male, Western Area, IDI-21)

For the main income providers in the families, salary was important as it is used to support their children's education, up keep of their homes and external family.

'...the most valuable to me is my salary because it is the one I use to run my family right' (Male, Koinadugu, IDI-12)

Salary was also seen as very important as it is pensionable.

'Because this is what going to give me my NASSIT (pension scheme) tomorrow, because what you work now is what part of it is saved for you when you, in your pension years and then you have something for the future' (Male, Kenema, IDI-6)

'Of course the salary is most dependable one, because it is pensionable, you expect to get it someday'.(Female, Koinadugu, IDI-8)

'.....because first of all if I retire today that is the one which will give me my gratuity and pension' (Male, Western Area, IDI-17)

In general, health workers felt that salary scales should be revised to reflect the qualifications gained. The responses of CHOs also echoed this point as they were disheartened that there was limited career progression with their role.

An example was given wherein over a 15 year period the change in salary was slow, not encouraging and not in line with the cost of living, even with the salary uplift introduced in 2010, meaning health workers were living in sub-standard conditions.

'.....it was very slow it was not encouraging, according to the condition of living in a country or the standard of living, it didn't match so at the end instead of improving the lifestyle of the staff it were, it were deteriorating because we cannot it cannot match with inflation'(Female, Western Area, IDI-20)

It was also reported that even though the majority of the health workers in this study felt that their salaries were their most valuable source of income, there was not much change in the salaries of

health workers until the onset of the FHCI. Likewise, there has not been any reported increase in health workers salary since the FHCI salary uplift.

'There has not been any substantial change in the provision of service. It only came after the free health care' (Female, Western Area, IDI-18)

'....by increasing the salary to meet the status of the country. Since our salaries where increased in 2010 they have never increased it, and the cost of living is increasing' (Male, Bonthe, IDI-2)

There was one report of health workers not receiving their salaries on time. With salaries being the main source of income, this had a negative impact on the health workers in question.

'... some people for no reason at all they are working and they go to the bank and they come Matron my salary was not into the bank, 3 / 4 months and it's so difficult and sometimes even to get that money back you would have spent more than what you would be paid back to you' (Female, Western Area, IDI-14)

In general the salary uplift that was introduced with the implementation of the FHCI in April 2010 was perceived as positive but not sufficient to retain staff. It was recommended that the salary scale for health workers should be revised.

'Like I said earlier even with the last salary increment what they are paying us is not enough to take care of our families, care for your children, provide feeding for them; like what I am receiving is just barely enough to take care of my family so thinking about having accommodation, medical bills, transportation, paying fees for my children ...[...]...and when they recruit these staffs they have to review the salary structure based on the cost of living, the present day cost of living. I'm not disputing the fact that the increment was not proper, ok, it was very timely and it was nice they did that one, but from that time to date things have change drastically; inflation heighten, even now if you look at that salary it's only the amount in words is good but in practical term it's doing the same that is used to do in the past. So salary structure needs to be revisited' (Male, Kenema, IDI-5)

'....and frankly speaking even up to now things are they are not that good, although we have well improved from 10 years ago to now but up to now we don't still have mechanisms in place that will attract or that will stop our people from flying to overseas, from leaving. Still we are still behind a little bit, although when it comes to provision for those actually we give service to, the patient I can say we are much, much, much more better when it comes to those who provide the service we are still behind' (Male, Western Area, IDI-19)

One respondent working in a hard to reach area felt the salary uplift was not in line with her performance on the job. Due to staff shortages she is constantly inundated with work, resulting in her working round the clock in performing her duties.

'Well according to my performance, my performance is higher than my salary, because of the type of work I am doing. 24 hours I am working but am not paid for 24hrs, but for humanity sake, to save lives' (Female, Koinadugu, IDI-10)

Remote Area Allowance

The remote area allowance was not seen as valuable by any of the respondents, due to delays in payment or the absence of it completely. Since its introduction in April 2010, up until the end of this study period (October 2013), approximately fourteen payments should have been made to health workers who qualified for RAA. However, the health workers in this study received a minimum of no payment and a maximum of four payments throughout this period (i.e. April 2010 to October 2013).

'The salary has improved a bit but there are a number of other things we should be getting that are not forthcoming. Like the remote allowance. Ever since it was introduced in 2010 we have only received it for two quarters' (Male, Bonthe, IDI-2)

'The remote allowance I think they paid for 3 quarters' (Male, Kenema, IDI-5)

'.....before this time we use to have the remote allowance but I could remember since 2010 they instituted the remote allowance I only received it once so that is not encouraging at all' (Male, Koinadugu, IDI-11)

However, allowances are valuable to health workers, highlighting the fact that the MOHS should endeavour to make the payments on time and keep health workers motivated.

'Well the two they are still valuable, the PBF and the remote allowance because I can say that they are always timely because you are always needing the money when they come in; they can help you to offset some of your problems, so I can say they are all valuable. Those three, those two with the salary' (Male, Bonthe, IDI-2)

It was also reported that health workers are not notified when these allowances are paid into their bank accounts. Thus it is possible that the correct frequency payments made to health workers is not captured in this study.

'..... sometimes the banks don't inform you. They are being paid directly into your accounts, and sometimes you hardly take notice of it, except when you see your balance, when you withdraw money so see your balance..[...]...we are not informed..[...]....anything that is coming in that is extra to help you I think is nice' (Male, Kenema, IDI-4)

Some health workers posted to rural areas were also ignorant to the fact about receiving RAA.

'Well I don't know. That is the fact, I don't know. All I know is that I receive monthly salary. If there is any allowance I don't know' (Female, Bonthe, IDI-1)

RAA was introduced as an incentive to motivate health workers to work and stay in rural and hard to reach areas of Sierra Leone. But the reported irregularities will have the opposite to its intended effect. A health worker working in a hard-to-reach area felt that there was no difference in the monthly income of those working in the cities compared to those working in the hard to reach areas. One health worker also working in a hard to reach area had heard of RAA but had never received it.

'.....rural allowance right and we are not seeing none of these things on our salaries; we do not see the differences between this and our colleagues elsewhere right and we are we are living in very hard to reach areas which are not easily even navigable by even motorbikes. ...[...].. we haven't seen

anything significant in terms of motivating us to stay in so some of us do not know, don't believe it is in existence' (Male, Koinadugu, IDI-12)

Performance based financing

Out of the 23 respondents included in this study, 13 were in receipt of PBF, 8 were not in receipt of PBF, mainly due to working in hospitals not currently under the PBF scheme, and 2 rural posted respondents had never received any despite working in health facilities included in the PBF scheme. Only two respondents felt that PBF was a valuable source of income, one of which had never been in receipt of PBF but felt it would be a valuable, although the anticipated PBF amount did not reflect the workload.

'Well it depends on the share you get...[...]. Its less, that is why am saying it is not enough...[...]. Due to the work load, I don't expect less than at least one million leones. In three month maybe they just give you Le 500,000 and they expect you should do more. I don't know how they do their assessment or grading, and am a senior staff member. If I am getting that what will the other junior staff will be getting, although I don't know if we are giving equal share, honestly' (Female, Koinadugu, IDI-8)

Again the respondents were not satisfied with the delay or irregularities in the PBF payments. As with RAA, the payments actually received were much lower than the expected payments. In one case no payment had been received despite the PBF assessment being carried out.

'the constraints.....it's not on time because the one they gave us is still last year, they have not even finished the third quarter last year so we have a fourth quarter and then we begin again this year; it's not on time' (Female, Western Area, IDI-20)

'No that money isn't forthcoming' (Male, Bonthe, IDI-2)

'We got only two quarters, because they pay that quarterly. We got 2 quarters in 2011. The remaining 1 quarter we did not get since the inception of that. 2012 we did not get anything up to date' (Male, Bonthe, IDI-3)

'Well as a matron I have never received a penny' (Female, Kenema, IDI-9)

'But the only thing, the challenge is that the PBF is not coming on time, it takes time, 2 to 3 quarters to receive one and it's very very challenging anyway' (Male, Koinadugu, IDI-11)

One respondent reported disparities between the regions, with Freetown being ahead of areas in the provinces in terms of PBF payments received. He went on to describe the whole PBF process as 'ridiculous' as the payments were late, which had a negative impact on the running of the health facilities.

'.....even with the advent of the performance based initiative when it had been paid almost a year in Freetown it had not been made available for us...[...]. it is ridiculous. How can you talk about performance based you are going to pay in 2011 you come and pay it in 2012? What do you expect this health worker to do? Where do you expect him to buy materials to run this health facility? Where do you expect this health worker to raise finances to run his health facility?' (Male, Koinadugu, IDI-12)

User fees

User fees were not seen as a valuable source of income. Maternal and children's hospitals do not charge user fees and the bulk of patients treated in other hospitals are under the fee waiver of FHCI (i.e. pregnant women, lactating mothers and children under the age of five years). A cost recovery system is in place for non-FHCI patients but the funds generated from that are used in the running of the health facilities.

'...yeah the hospital receive user fees its minimal because before now you know the pregnant women and children are using most of the facilities you know but this adult men and women they only come to hospital when they are very, very sick so you see the user fee is very minimal and there are a lot of things to do in the hospital' (Female, Koinadugu, IDI-9)

'Well we only take user fee for cost recovery drugs but we have not been having this on a regular basis' (Male, Kenema, IDI-4)

Gifts from patients

Health workers receive gifts from some patients as a way of showing appreciation or as payment. This particularly occurs in the provinces and usually takes the form of food items.

'We appreciate it, not all patients, some are grateful, some don't pay, some go come with gifts in kind, I mean, (Male, Koinadugu, IDI-11)

'Gifts yes, they give me some form of food items' (Male, Western Area, IDI-20)

Some health workers find themselves working in deprived communities making it morally impossible to accept gifts from patients and in some cases, find themselves giving them to the community. Some health workers have been sensitised to not accept gifts from patients for professional reasons.

'Most people want you to give them and at times you have to sacrifice to give them.' (Female, Bonthe, IDI-1)

'...no we don't receive gifts from patients especially in this area because they are sensitised that a nurse should not receive any gifts from patients, so they are well sensitised' (Female, Koinadugu, IDI-9)

Gifts are valuable to health workers working in the provinces; one depended on gifts from patients during their unpaid early training period, and described it as valuable compared to PBF that was unpredictable. For one respondent, gifts from patients were his main source of survival as he spends his entire salary on supporting his family in Freetown.

'...as I told you already I said I did not have salary within my training.....[...]...from the time before I was employed had it not been for those gifts these people give us some of us should have been devastated at the PHU level....[...]...The gifts I receive are most beneficial they are immediate. I see them, I feel them, I am not sure when this performance is coming right but these gifts keep me up every day right, these people appreciate me...' (Male, Koinadugu, IDI-12)

'the little gifts I receive from my patients is what I keep and run myself' (Male, Koinadugu, IDI-11)

Other sources of income

Other sources of income from private businesses e.g. shops, private health care practices, petty trading, were used to augment the monthly income for 7 out of 23 respondents.

Private medical practice and other medical activities

Sources of income under this category include owning private medical practices, lecturing at medical school, doing health related surveys, training staff in MOHS, per diems for attending technical workshops and allowances for senior level cadre health professionals. Other sources of income include incentives from NGOs which are available to some health workers in some health facilities, on a performance based model.

'Per diem...except you go for workshop' (Male, Bonthe, IDI-3)

'The only other activity I am involved is within the MOH. If there are surveys to be conducted within the MOH I am usually called upon to participate...[...].If there is training being conducted by the MOH, training other staff members, I am usually also involved in this' (Male, Bonthe, IDI-2)

'Well I am an associate lecturer at the College of Medicine because when you keep yourself in the position you would not forget your books' (Male, Kenema, IDI-6)

One respondent in addition to working for the MOHS was also a private doctor for a company in Freetown, in addition to running a private practice. He wore many hats throughout his career to increase his monthly income and even with the improved salary scales currently appealed for the Government to do more for health service providers.

'I do have a private practice' (Male, Western Area, IDI-17)

Private non-medical business

Non-medical related sources of income include private businesses; an activity one respondent felt could be avoided if his salary was substantial. Another respondent was involved in agriculture to augment his 'meagre salary'. It was also observed that only one health worker on a rural posting (who was based in a rural city) reported about being involved in private businesses. Those posted in the hard to reach parts of Sierra Leone did not report being involved in private businesses, possibly due to the nature of their working environment and the economic climate in the remote parts of Sierra Leone.

'so one has to do extra job, like what I usually do I engage my wife into extra businesses, petty businesses. So that's how we are able to raise extra money to be able to care for the children. I should be able to take care of them I should not be subjecting her to the kind of strain that she is going through if my earning is sufficient to take care of us' (Male, Kenema, IDI-5)

'I have a small shop, I sell cosmetics, I wanted to open it as a pharmacy but I had difficulty of getting a pharmacist so for now we are just selling cosmetics and drinks, water..[...].it's helping a lot' (Female, Western Area, IDI-16)

A senior cadre health professional had to be involved in non-health care related work to increase his monthly income and earned seven times more in that line of work compared to his Government salary as a specialist doctor.

‘...well they didn’t actually come at the same, ok let’s say the part time job was the first actually I got and the well they are giving almost was it 6, \$700 a month just imagine the Government giving me \$100 so that continued for erm almost close to one year’ (Male, Western Area, IDI-19)

9. Experiences and perception of incentive policies

Perceived effects of the Free Health Care Initiative (FHCI)

As already mentioned, the most significant change that directly impacted health workers as a result of the FHCI was the salary uplift for health workers. This had a positive impact on health workers in general and improved the dedication of the medical personnel to service.

‘There was a huge jump, it went up to about Le700, 000(seven hundred thousand Leones)..[...].Well I felt good though it was not quite enough, but it was better as compared to what we were having before this time’ (Male, Kenema, IDI-4)

‘Well we can mention Free Health Care though it is as recent as 2010 and that one is actually eventful as you have rightly said, because it brought a lot of changes in the work, movement of personnel and dedication of personnel to service’ (Female, Koinadugu, IDI-8)

It also brought about an increase in the utilisation of services amongst the intended vulnerable group of service users, which increased the workload of the health workers. This increase in workload was seen as a challenge for a number of the health workers.

‘.... the workload is increase, because now the categories who have been named are the most vulnerable and even before the free health care those are the people you see mostly in the clinic; the sick children, pregnant women, suckling mothers, these are vulnerable people. Even at normal times when there was no free health care these are the people that you see mostly. So when the free health care comes, well that one compounded everything. So they are coming, they are coming...[...].if a clinic there is only two people there and with the emergence of this free health care, we are now seeing a lot of people, they are over-burdened with work..’ (Male, Bonthe, IDI-3)

Some health workers felt that the salary uplift was not in line with the increase in workload and other motivating measures should be put in place to retain health workers. The FHCI also brought some additional challenges to health workers other than the increase workload. Recipients of the FHCI were not properly sensitised and expected everything to be provided for free.

‘ but only for anything that is free is a bit challenging, challenging in the sense that most of the patients that do come in they expect everything to be free; free medication, care of their newborn even giving them Pampers should be free but in that area not all of those things are provided by the government’ (Female, Western Area, IDI-15)

‘.... we had problems already ...and now we have enormous amount of patients coming, lack of adequate supplies, drugs are short, materials are not there and then these patients come and the old challenges I have already mentioned are still in place and then the burden more burden has been added to us. I feel in fact this is a burden that is going to crack our back and that is why some of us are worried, that if we were not properly motivated then certainly we are going to leave the Ministry of Health because with the advent of the free healthcare more burdens has been given to us. More

responsibilities with less motivation, I am not talking our salaries but at least incentive’ (Male, Koinadugu, IDI-12)

In one case, a health worker reported having to close down his private practice to deal with the increased traffic of patients at the health facilities.

‘so when you have free healthcare and people start coming to those I closed the place and I rented it to somebody else and I came to the hospital and by then also er I was almost the head of this hospital there is too much work’ (Male, Western Area, IDI-19)

The impact of the FHCI on the health system has been both positive and negative. The FHCI increased the utilisation of the health facilities, resulting in more institutional deliveries. TBA deliveries were reported to have reduced as the government has introduced a fine for TBAs conducting deliveries outside of the health facilities. TBAs are also encouraged to refer women to health facilities and in some places, they receive incentives from the health facilities for doing so. In addition, TBAs are invited to participate in workshops centred on child and maternal health and work with community health workers to ensure that women have safe institutional deliveries. Women's visits to health facilities have increased since the implementation of the FHCI, e.g. for antenatal care (ANC) and immunisation.

‘...people are making use of health facilities even the institutional deliveries’ (Female, Bonthe, IDI-1)

‘before now we, people don't really make use of the facilities; actually the pregnant women they only come when they have problems when they have complications, but now we can see them just walk in, into the hospital because of there is no cost attached to the services, they will come to have their babies and also the under-fives they will make use of the facility for the immunisation and even the ANC Ante Natal Care, they will come to the hospital because there is no cost attached and also there are drugs’ (Female, Koinadugu, IDI-9)

‘because now when we have this free health we have laws, that no women should deliver at home or no TBA. But at first when there was no free health these TBAs they did the deliveries at home. So now it's a different, because now if you deliver any pregnant woman at home you are going to be fined. So as soon as any pregnant get to the TBA she will say,’ No, let's go the hospital’ (Female, Koinadugu, IDI-10)

‘.....another success could be instead of going to traditional birth attendants.....[...].because they were having a lot of complications with TBAs traditional birth attendants but now we are happy because they TBAs even themselves come with them now[...].the role of the community also is a success because even the TBAs were holding on to the patients but because Ministry of Health is now calling them to workshops, involving them in other activities like community health workers; now they are policing the people in the community ensuring that they live a healthier life so their role also have changed ..[....].....which will have a great impact; instead of trying to give native medicine at home now it is having a great impact wasting the patients time having great impact now because people come to us nowno complications’ (Female, Western Area, IDI-20)

‘.... I was at Ola During when it started and the influx of patients I saw, it was overwhelming, I was so happy that people who were afraid in the former days to come to the hospital because maybe they were not having money they think they will be charged and so on are coming in hundreds. ...[...].so if

there was no free health all these children who are so ill looking, these children who are so sick these parents who look so poor would die somewhere someday not getting any care....[...]...The antenatal clinic sometimes you would go there you would have 4/5 patients for the day now you have up to a 150 patients in one day coming there and they prefer coming here because they get drugs if they are admitted, they are admitted, no admission fee, no bed fee and you have 3 meals a day's' (Female, Western Area, IDI-14)

However, one health worker reported that some rural areas of Sierra Leone are still ignorant about the FHCI, and that women do not utilise the health system for deliveries.

'.....in those remote area they are still ignorant. They don't know about this free health care and they don't know about hospital delivery' (Female, Koinadugu, IDI-10)

Health facilities were described as being more user-friendly or more accessible due to the FHCI, with health workers changing their attitude towards service users. It also highlighted the dedication of the health workers to service. There have also been improvements in the infrastructure of the health facilities. Donor agencies like UNICEF are involved upgrading some health facilities to BEmONC centres. This involves training staff in specialised skills relating to child and maternal health, which in turn improves the quality of service rendered.

'Well one of the changes is now the hospital is a bit user friendly..[...]...In those days before the war people were paying for service, but now with the free health care and a lot of trainings going on, it seems as it nurses are changing their attitude. You see...And then the accessibility is the hospital....the patient and they are utilizing the hospitals as compared to before' (Female, Kenema, IDI-9)

..... it is free healthcare that came about with implementing Human Resource because they have strategic number of people who should be at the health facilities now at any level and ensure they are there like BEmONC...[...]....they give us more like here we have three midwives now because this is our target to have a standard obstetric and newborn care services and then they extend it to the others..[...]....the staff that is needed and the new born care also because those are stages that normally we will lose our babies and even the mothers.....[...].... more staff at the health facility and the training of these people to tackle these cases that have been killing p mothers and children..[...].....and the development of the health facility..[...]....as soon as we became a BEmONC centre UNICEF came to let us have 24 hours, they gave us a water tank, 24 hours running water..[...]....and they also provided us 24 hours electricity because in the absence of NPA (energy provider in Sierra Leone) at night we can put on our solar...[...]....24 hour throughout the night the solar are on so it makes the environment very conducive for work' (Female ,Western Area, IDI-20)

'in the nineties let me say for instance the matron of the whole hospital, she has to rent a house and to share it with another person; but now since the introduction of the free healthcare they are now quarters although there are not enough for all the staff but at least for the senior staff there is housing facilities and even in the drugs there are drugs for the for those in the free healthcare' (Female, Koinadugu, IDI-9)

Recording keeping has improved in the post FHCI period, as required for the PBF assessments of health facilities. In understaffed health facilities, dealing with the increase patient numbers and fulfilling record keeping requirements is an additional burden or constraint.

With regards to negative effects, the increased workload was the most cited. Limited human resources means health workers are over stretched, especially in the provinces, work very long hours and have to be available 24 hours. This sometimes leads to complications with care as some health facilities cannot cope effectively with the number of patients coming through.

‘Because we are working 24hours and we are not, it’s not like a hospital where you have routine doctors, we are the only higher cadre personnel that work 24hours so the work is strenuous, before this time people are not coming because of finance but now once they remove the users fees people are coming 24hours’ (Male, Koinadugu, IDI-11)

Some facilities reported that organised systems were in place for drugs and medical supplies. On the other hand, some health workers also expressed concerns about the sustainability of the FHCI in general and also about the effectiveness of the current drug supply system.

‘Well the free health care is moving on, but my only fear is the sustainability of it, because things you have started and you are not able to sustain it, it will be a catastrophe in the end. Then again there are certain drugs which are supposed to be in Free health care but sometimes they come in very small quantity and that cannot even take a week, they finish, and then patients, most times they grumble a lot’ (Male, Bonthe, IDI-3)

Despite sensitisation exercises carried out on the radio, TV and via text messages, a number of health workers reported that service users, especially those in the rural areas, have a different perception or misunderstanding about the free health care drugs, as the drugs are being misused. Instances were reported in which service users will acquire drugs from different health facilities, for the same ailment and within the same timeframe. These drugs are then in some cases, sold by the service users, a practice that has a negative impact on the health facilities, as sometimes the drug supply is low or not available. Therefore, stock levels should be maintained and used for those who actually need the drugs. In addition, when sold on, these drugs can have detrimental side effects on those consuming them.

‘Again the other problem is the sensitization of this free health centre has not gone down too far, particularly in the rural areas...[....]...a patient can come to this clinic, with a sick child or herself, pregnant woman or suckling mother, come here, get drugs, the next day goes to the other place, she will not tell you the correct history, that she has got some drugs, collect drugs; sometimes they go with these drugs and sell it to people’ (Male, Bonthe, IDI-3)

‘Even when they are not sick they will come for it except when we are educated, so that was the challenges we have, at first people were coming to collect medicine and there was proof, community people, people living in the community gathering the medicine thinking medicine is something you can just take it’s our right...[....]...I thought the education was not enough before the implementation, the sensitization was not enough, people you have to tell them about the side effects of drugs, they should be well educated and what dose of drug, what is the effect it will take and that this thing is going to continue it’s not just coming to go, it should be sustained’ (Female Western Area, IDI-20)

A major perceived unintended effect of the FHCI is the increase in teenage pregnancies, partly due to peer pressure and due to the notion that having a baby is free, as reported by the health workers.

‘And then when you look at the challenges again faced now with the free health care let’s say teenage pregnancies, you find out that the hospitals have to do a lot of caesarean sections because the bulk of the deliveries of pregnancies are coming from under age children 13, 14 years of age, that’s a child mother’ (Male, Kenema, IDI-6)

‘and what I also observe is the teenage pregnancy which is at a worst situation now that is happening...[...].and they see their friends maybe peer group influence somebody have gone through and have the baby without spending money’ (Female, Western Area, IDI-20)

‘It’s a step in the right direction...[...].I think the whole idea was to get women to come into hospital to have a clean safe delivery. But our young ladies are abusing it...[...].because all you see is as young as 12, 13, 14 yeah, 15, they are the ones having babies now. And one of them say “Oh I will have my baby the President will take care of it” (Female, Western Area, IDI-23)

On the same note, another health worker recommended that the health facilities need to improve the utilisation of family planning to avoid the increasing rates of unwanted pregnancies amongst young girls.

‘...unwanted pregnancy now but it’s on the increase now, it’s on the increase, and that will create a lot of dropouts from school...[...]. maybe we need to put strategies in place for the uptake of family planning and introduce it in the schools’ (Female, Western Area, IDI-20)

In this particular health facility, availability of space is a major concern, as it limits the number of activities that the health facility can deliver effectively. In her opinion, the lack of privacy in the health facility deters young girls and other women from participating in family planning services offered at the health facility. Some health workers also reported that the lack of vital equipment to strengthen the health system is lacking.

‘...we are having this problem like if we have enough space now for adolescent health, where we say there is a room special for them where we try to educate them on what to do and what not to do in their adolescence, that one can minimize maybe even the early pregnancy, teenage pregnancy, STIs, sexually transmitted, HIV infections all these things because if they see from films or they hear from us but they cannot come into here it is not friendly you know...[...].you see them coming sometimes maybe the reason even why they don’t come for family planning because they don’t want people to tag them other patients there is no privacy’ (Female, Western Area, IDI-20)

‘even before the free health going towards free health after the war , we found out that this building is too small because the influx of patients that were coming, especially when I was at the Children’s Hospital we started admitting 2 patients per bed even before the free health came and that was a concern. We had beds but there were nowhere to put the beds because of space...[...].now that we have the free health it is almost 300% small with these people just coming in’ (Female, Western Area, IDI-14)

‘patients come and some health staff cannot perform some, key functions, lifesaving functions, so definitely they have to refer and even if you refer, we only have like one ambulance here or two that

have to visit all those 68 PHUs. So let's say for example, it happens that two or three PHUs call at the same time to go and collect patients by the time they go, another call, where do you get the vehicle to go. We don't have enough drivers, I mean those on payroll..' (Female, Koinadugu, IDI-8)

Perceived effects of the Remote Area Allowance (RAA)

RAA is a potential motivating factor for health workers posted to rural areas of Sierra Leone. It was perceived by health workers as a good initiative that could change the way they work, negating the need for a second income and enabling them to focus on the job. It could also serve as a means of motivating health workers to stay in post compared to the situation before RAA, when some rural postings were not honoured by health workers. However, a number of concerns were raised by health workers about the RAA, mainly about the irregularity of the payments. Some health workers reported not receiving any payment for a long period of time; one health worker was discouraged that his RAA has never been paid despite the fact that he is working in a rural area.

'That was one policy I was really happy about because when you look at the way it was rated, the more remote area you work in the more money you get, which will encourage somebody to stay. But these monies are not forthcoming and this has started discouraging staff posted in remote areas' (Male, Bonthe, IDI-2)

'Well it's....the only way its help you is to keep focus, because if you are having some additional money and then you are reducing the problems that are worrying you, you can have time to concentrate on the job. I think that's the main way its helps' (Male, Kenema, IDI-4)

'Well some of them told me that they have been receiving some amount...[...]..... I feel discourage..[...]....Because I'm also up the provinces you see, whether its urban or rural as long as you are in a region you are up the provinces you should be included' (Female, Kenema, IDI-9)

Health workers in rural postings feel neglected by the government and call for this incentive policy to be revised, possibly with input from its beneficiaries. One reported that as there is often no electricity and water supply in these rural postings, regular receipt of RAA will help make meeting other expenses to improve their living conditions, such as buying a standby generator, affordable without digging into their salary.

'well some of the policies because they are not involving the end users, I think sometimes there are problems because if the end users are involved in the policy making process, the end users they will give input, they will give problems what and what to do so you see some of these policies if they involved end users those of us in the grassroots sometimes it will create an impact' (Female, Koinadugu, IDI-9)

' It worked once, for the entire 2011 and 2012 we only receive once...[...].....people need to do certain things, it's like people are neglecting their duty...[...]....People up there, because one thing about Government policy or things happening in the Ministry, people need to do something before something happens. If you have to do your work, somebody up there needs to do something but to another level, people are just neglecting it because perhaps it's not in their own favour, but once it is in national favour they need to do that so as to things to work up fine' (Male, Koinadugu, IDI-11)

‘...because when I receive that one it will motivate me for now there is no electricity there is no water supply, so maybe if I receive that remote area allowance I will try to get a standby generator you know to improve my livelihood you see’ (Female, Koinadugu, IDI-9)

Another reported that payments are not consistent and the payment system needs to be restructured, as junior staffs are in receipt of RAA with a higher monetary value compared to senior staff within the same health facility. Health workers feel that they should be involved in the calculation system to have some insight and input into how RAA is disbursed.

Another issue raised by the health workers was that those working in big cities, e.g., Kenema, are not considered to be working in rural areas. An example was given of a health worker from Freetown posted to Kenema and classified as not eligible to receive RAA; however this individual has family home to support in Freetown in addition to supporting himself at his posted location, on the same salary as other health workers, who only have one home to support.

‘Well they have a policy called rural posting, if they post you to the rural areas then they will give you some allowances, but what I understand under this rural posting is relative towards cities or non-cities. So if you are in Kenema, Kenema city is not considered a rural posting if you are posted from Freetown to Kenema but then the workers don’t want to understand that; say I was in Freetown, I was born and breed there, I went to school there I studied there and now you are sending me to Kenema where I don t have any relatives and you do consider that a rural posting; that what the argument is saying. They said Kenema is a city, Makeni is a city, Bo is a city Freetown is a city. So if you are working in any of these area that’s not a rural postings...[...]. Well I don’t know am not sure because we are not benefiting from it. Now they consider rural if you posted from say to areas like Kailahun, Pujehun, Moyamba, that is what they will say is rural because they don’t have a centralized electricity supply..[...]. Now they need to revisit these things. Why? Let’s say somebody is coming from Freetown who has never been to the provinces and you send that person from Freetown to Kenema. If he is married maybe he is not coming with his wife....[...]. he has to keep two homes...[...]. the children are going to school in Freetown and he is here, he has to support them that they should be considered also. So I don’t believe simply because you are living here you have a centralized power supply and water supply that does not make it a rural relative to Freetown’ (Male, Kenema, IDI-6)

In this regard RAA should serve as both compensation and motivation, therefore it is recommended that the policy needs to be revisited and regularised to have its intended effect on health workers.

Perceived effects of the performance based financing (PBF)

PBF is an incentive allowance, introduced on the back of the FHCI to have a direct positive impact on health workers and health facilities. PBF allowances are calculated based on achieving a number of targets as a health facility and also as an individual. Of the PBF allocated to a health facility, 60% is used to pay health worker incentives and the remaining 40% is used to improve the health facility. Thus health workers are expected to put in a lot of effort into their work, as the more you work, as individuals or as a team, the more you earn with regards to PBF. PBF gave a sense of accomplishment to one health worker, as it assesses your effectiveness and efficiency at work as compared to user fees, where health workers earned a lot with no measure of accomplishment. It has provided job satisfaction for the health workers as the amount they received is based upon both

individual and teamwork effort to achieve the PBF grading criteria and creates a conducive working environment for health workers, as the health facilities are maintained. It has also raised the awareness amongst health workers that they have to give improved quality of service over quantity of service users treated, as reported by one health worker. PBF was described as valuable and encouraging, having a positive impact on health workers and the health system. It was also described as not forthcoming and appreciated but not enough when compared with the cost of living. Thus it was recommended that the government should do more to ensure that payments are made on time to keep the health workers dealing with the increased workload motivated.

'That was also a good motivation that would encourage people to work hard as the harder you work, they more money you will get. But again this is not forthcoming. People working hard for the whole of 2012 and have not received a single cent. It seems as if they are saying the DHMTs is receiving the monies but this is not being given to the health workers' (Male, Bonthe, IDI-2)

'The only way its help you is to keep focus, because if you are having some additional money and then you are reducing the problems that are worrying you, you can have time to concentrate on the job. I think that's the main way its helps' (Male, Kenema, IDI-4)

'The PBF came in as sort of motivation to add more effort because it has some criteria that you have to meet before you get it, so it gave me the urge to put more effort to what I was doing than before...[.]...The PBF has helped a lot...[.]...It has created awareness among the health staff that they have the responsibility to improve the quality of the service they provide for the patient, because PBF all about....is not just about quantity of service provided it also looks at the quality of service you provide..[.]....so with that staff have become so conscious and are becoming aware of the fact that they have to improve the quality of service they are providing' (Male, Kenema, IDI-5)

'Before this time people use to pay, you know the pregnant women, the children under 5s and lactating mothers they are the clinic attendants. When they come before this time they used to pay Le10,000 per child, you see about 50 or 100 children or pregnant women it's good money; but now it is free, but government is saying they are going to compensate, it is not a pay per se but a compensation at least to serve as a motivating factor, but this PBF it is good anyway and it should continue but the only appeal is that it should be in time, it should be in time, no matter how little it is it should be in time, we will appreciate it' (Male, Koinadugu, IDI-11)

'Yes, some have doubled their efforts a bit, and some others only when they know the PBF is on the way that is the time you see them doing their work, doing what they are supposed to do, but we do encourage them to do what they are supposed to do, somewhat to go strictly by his or her job description, because I always tell them if you don't do this, you only will spoil the whole PBF, because if you are supposed to clean this area, when they come on supervision cleanliness is part of it, if you are supposed to have 7 just because the compound is dirty, the environment is dirty they subtract 3 then you get 4, and you spoil everybody's effort, so it's like a teamwork, we have to work as a team if we want our PBF to swell up.' (Male, Western Area, IDI-21)

One health worker was not in receipt of PBF but reported that she was still committed to her job. In the provinces, PBF (first phase) is only paid to PHUs. Therefore health workers stationed at referral hospitals currently not receiving PBF are demotivated as they deal with child and maternal referral cases from the PHUs.

I've not received my PBF but I am still working it has changed because I know as long as I am working I will receive my PBF' (Female, Western Area, IDI-16)

'Another issue for the hospitals becausewhen patients have been referred from the primary health care...[....]...we are the only referral hospital in district, so if we don't have this performance based it is so demotivating; ..[...].nurses are always grumbling that the PHU are receiving this performance based and they are doing almost the same thing and we are, in fact, we are doing more than them because when they are tired they refer to us in the hospitals...[...].so if they can advocate for us especially for the hospitals to have this performance based it will even motivate the nurses that are working surely for the free healthcare because sometimes when you call them for operation they will always say we are not receiving performance based allowances' (Female, Koinadugu, IDI-9)

PBF was described as valuable and encouraging, having a positive impact on both health workers and the health system. For instance from the 60% some health facilities can give TBAs incentives to motivate them and help increase institutional deliveries and also pay porters and cleaners to help maintain cleanliness in the health facilities. It plays an important role in implementing government policy and reducing TBA births. Institutionalised deliveries have increased with a simultaneous decrease in TBA deliveries as service users and TBAs are more sensitised about institutional deliveries.

'The hospitals are cleaner; I don't know if you have gone to other hospitals, I mean I can boast my hospital is the cleanest hospital in the entire let me say country.....[...].we decide as a hospital how the money is going to be used we have been putting most of that money 1. in hiring of volunteers, we have volunteers we are paying because we don't have enough staff, there is no staff here those porters, cleaners people in the kitchen you find they are not enough. We hire them and we pay them also on a quarterly basis, we pay them as and when we get PBF.' (Male, Western Area, IDI-19)

'....we motivate the traditional birth attendants to come and work with us. I take pride in working because those are the grass root people, if we are giving them something on quarterly basis it's like they are on salary, meaning they really appreciate it and it gives the chance for them to really take the government policy into practice [.....]to stop the practice of home delivery [..]before this time people were not sensitized about their health, they didn't take advantage of the clinic that is been provided for them; we have tried to change that mentality..[...]. and also people believe that delivery should be done by the native people in the bushes, we've changes the dimension that delivery should be at the hospital, it has to be skilled, so as for the life of the mother and that of the foetus, the baby' (Male, Koinadugu, IDI-11)

It also serves as an effective means of enforcing discipline in the workplace, with regards to punctuality and dress code, free of political interference.

'So we introduced by-laws as to when we can punish or discipline you by taking some money from your PBF..[...]. by-laws say if you are supposed to be here at 8 o'clock and you don't come until after 9 o'clock we draw a red line there it means you have lost 10,000 Leone for that day; if you are supposed to be on night duty it's 20,000.....if it's on weekend you've lost 50,000 Leones...[....].this is the way we punish people here because actually we don't have the power. If we say "You go home and don't come to work for one week" and this person whether it's a nurse or whatever will go home

very happy because still at the end of the month he/she is going to the bank and collect a month's salary' (Male, Western Area, IDI-19)

It has also had a positive impact on record keeping in health facilities a measuring target in the PBF assessment.

'...like record keeping...[...]....at time when there was no PBF except you go and seat there you see somebody performing and not even recording it. So now they know the more they record the people and sometimes like family planning they go and give it at home but now they come with the patient here and they make sure they enter the data' (Female, Western Area, IDI-20)

As mentioned earlier, 40% of the PBF amount is used to improve the health facilities making it attractive, in terms of drugs availability and repairs, and accessible to the increased traffic of service users.

'Yes greatly, because we have leaking roofs, we have repaired that, we have resurfaced the paint that was once used on that, buy some drugs, some syrups for under 5s and some basic drugs used by pregnant women, and they are coming, you know in Waterloo we have, there are other 7 PHUs surrounded at our own facility and like we are their main referral areas....[...]....so we receive quite a good number of them, they are coming, some do appreciate although others, when they are coming' (Male, Western Area, IDI-21)

As mentioned above, PBF has created a platform to raise the awareness amongst health workers that they have to give improved quality of service to service users, which will strengthen the health system. Currently some health facilities are struggling to deal with the increased workload due to lack of personnel.

'we are all grumbling, I mean the patient load increased by, almost overnight, by 500-600% ...[...]... because when you have to sit here from 8 o'clock up to 5 o'clock you see almost 60-70 cases one doctor you are not normal anymore believe me you are not normal you cannot see 50 cases and say you are normal it is not possible' (Male, Western Area, IDI-19)

However, whilst PBF potentially adds to the overall income of the health facility, other policies were reported to have had an opposite health system effect. An example of this is the cost recovery system. A health worker reported that policies put in place from central government, presumably with regards to cost recovery drugs, needs to be revised. In his opinion cost recovery drugs are more expensive than pharmacy drugs and health facilities are expected to pay 100% back compared to 60% in the past. The remaining 40% was used to run the health facilities, including payment of security staff who are not on the government payroll system. With the current policy implemented in 2012 whereby health facilities are expected to pay 100% back, no allowance is made for the security staff that play in vital role in safeguarding the health facilities and minimising theft of drugs.

'.....again we are operating on two categories of dispensary drugs: cost recovery and the other one free health care. But if you look at the cost of cost recovery drugs, most of them are far higher than even those in the pharmacies. So I mean, and what they are saying that we should pay 100% out of it. Formerly we use to pay 60%. The 40% we use for the clinic and that is what we even use to pay the porter, the security and so forth. And these people they are not on salaries, and we need their services because of drug theft....' (Male, Bonthe, IDI-3)

Perceived effects of the salary uplift

The salary uplift was a motivating factor for all the health workers and changed the way they work in a positive way. However, there were different perceptions about the salary increase, with an underlying theme of it being a positive step that was long overdue but not commensurate with the role health workers play, amongst other issues discussed earlier. There are some disparities among the different cadres of staff, with nurses thinking that doctors have benefitted more from it. As mentioned earlier, the FHCI directly impacted the workload of the health workers; the increased workload meant the health workers had very limited opportunity to be involved in other activities to increase their monthly income. Accordingly health workers are advocating for extra allowances to augment their monthly income.

‘Like I said earlier even with the last salary increment what they are paying us is not enough to take care of our families, care for your children, provide feeding for them; like what I am receiving is just barely enough to take care of my family so thinking about having accommodation, medical bills, transportation, paying fees for my children’ (Male, Kenema, IDI-5)

‘But now they say nurse salary is increase but you do everything in that salary, you have responsibility, so I think that is not helping much because those day they leave to do extra things so they will be able to provide for themselves, they don’t care but for now they restrict them so much, they work so much 24hr, yet they don’t have much; it’s a problem.....[...].... Well they don’t have the time because the work load cannot allow you and you since are working 24hr and you know if any case is mismanaged in your centre you are responsible, definitely you don’t have to leave your work, you have to work’ (Female, Koinadugu, IDI-8)

‘... that’s not it does not reflect much on the nurses...[...]...it’s the doctors, but the nurses it does not reflect much it’s the doctors have benefited from that’ (Female, Western Area, IDI-18)

10.Recommendations for a retention package for health workers in rural areas

In general, health workers felt that making the job attractive by creating a conducive working environment, improved health facilities with improved conditions of service, decent staff accommodation or housing allowance, equal training opportunities, transportation allowance or transportation provided, improved salary scales, recruitment of more staff and regularisation of allowances pertaining to health workers in rural postings was the backbone of retaining health workers in rural postings.

‘In rural areas, make the job very attractive, by ensuring there are conditions of service, where they stay, how they move, what they get...[...]....That means an environment that is conducive...[...]... provide staff quarters. Yeah...I am talking about staff quarters...[...].....get them easy accessibility to move...[...]....for instance if I have my staff quarters, I have my solar light there, I want to play my video or whatever that I can do in big towns, I can stay there...[...].... let them improve their salaries, at least remote area allowances should be regularised’ (Male, Bonthe, IDI-3)

In addition, health workers felt that there should be an element of modernisation in the health facilities by providing internet services and satellite TV. Some health workers also reported that the government should provide medical/health insurance for health workers.

‘....if possible electricity, it could be solar and actually upgrading this distance settings with some modern gadget like internet facilities or you can even have multi TV [satellite TV] units...[...].you can be touch with what is happening all over the world’ (Male, IDIK1, Kenema, IDI-4)

The posting procedure should also be transparent with no political influence or otherwise with no disparities. Those in leadership positions should be given the right level of authority to manage the affairs of the health facilities with no interference.

‘....let’s make it [posting procedure] transparent and equal opportunities, that is to say if we know for sure that as a policy you send one nurse to one rural area, this nurse works for 2 years in that particular posting she has completed her posting and then she knows when she goes to Freetown somebody else will be going and it should be fair and it should cut across; but then there are some people posted after a while their posting will be withdrawn; it’s happening, some people are posted they never reported ..[...].and nobody is saying anything and they will chase others to go you have to go...[...].As long as people have confidence that this is operational, functional, it’s not discriminating, they will fall for it’ (Male, Kenema, IDI-6)

It was also recommended that a health workers’ commission should be set up that oversees the affairs of health workers. Health workers in rural postings should be updated about things happened in Freetown, something that could possibly be coordinated by the proposed health workers’ commission.

‘First of all, health workers we don’t have a commission that actually overseas our issues; so if they could create one of that that actually deal with all health worker issues, it would be better’ (Female, Koinadugu, IDI-8)

A performance management system should also be introduced ensuring that the right level of support for health workers is coming from the authorities. This would also minimise the attrition of senior experienced health workers, leaving junior recruits to manage the health care delivered in the health facilities unsupervised in some instances.

‘....we need, people need to do certain things, it’s like people are neglecting their duty...[...].because one thing about Government policy or things happening in the Ministry, people need to do something before something happens. If you have to do your work, somebody up there [MOHS] needs to do something but to another level, people are just neglecting it because perhaps it’s not in their own favor, but once it is in national favour they need to do that so as to things to work up fine’ (Male, Koinadugu, IDI-11)

‘Because I mean if the health system has to improve...[...].if they are to retain staff, because a lot of colleagues who are very competent are leaving the ministry, those that are experienced, are leaving the ministry right and the government is recruiting just those from the university. Right while the trained and experienced ones are leaving the ministry so it is, it is not helping the ministry at all’ (Male, Koinadugu, IDI-12)

It was also reported that control measure should be put in place to ensure sustainability of the recommendations listed below.

Financial incentives

The majority of the health workers both in rural postings and in Freetown recommended that salary scales should be increased and allowances should be regularised. Salary scales should be in line with the current cost of living and should serve as compensation for health workers not being able to engage in extra jobs to generate extra income.

'One their salary SHOULD be based on the economic status of the day. Two remote allowances meant for these health workers working in remote areas MUST be given to them on time and at the right time, on quarterly basis. Three the PBF must also be on a regular basis with no delay about it, because when somebody works for something they should receive it immediately' (Male, Bonthe, IDI-2)

'...and when they recruit these staffs they have to review the salary structure based on the cost of living, the present day cost of living. I'm not disputing the fact that the increment was not proper, ok, it was very timely and it was nice they did that one, but from that time to date things have change drastically; inflation heighten, even now if you look at that salary it's only the amount in words is good but in practical term it's doing the same that is used to do in the past. So salary structure needs to be revisited. And allowances, like the remote area allowances needs to be reviewed, medical allowances, to be paid to staff and their families' (Male, Kenema, IDI-5)

'Some were doing extra job [in the past], but they don't have the time because the work load cannot allow you, and you since are working 24hr and you know if any case is mismanaged in your centre you are responsible' (Female, Koinadugu, IDI-8)

'because when I was in Freetown I was working in two places, but for now everything is cut off, just my bare salary and I have my family in Freetown, I have to support them, so it is not easy. That is why we working up in the provinces, we should be motivated. Even the salary scale should not be the same to be sincere' (Female, Koinadugu, IDI-10)

This has a double edge sword effect as second jobs can distract health workers from the task at hand but on the other hand the combined salaries and allowances of health workers are not enough to take care of their responsibilities, especially those in rural postings having to run two homes. Health workers in rural postings do not have avenues to engage in second jobs because of the increased workload and lack of further employment opportunities in these parts of Sierra Leone. Allowances (RAA and PBF) should be increased and regularised, with one health worker recommending that allowances should be paid on a monthly basis, possibly to maintain high levels of motivation amongst the health workers. It was recommended that hospitals in the provinces should be included in the PBF scheme as nurses in the hospitals are demotivated by the fact that they have to deal with referral cases from the PHUs, who are included in the PBF scheme, without receiving any PBF allowance.

'Maybe fast tracking it [allowances] so that we receive it at least every month...[...]... And also for the hospital I think I mentioned about this performance based allowances to be paid in the hospital. Let them consider because it will motivate even the nurses to stay because most the nurses want to go

and work ...[...]... in the PHUs because in the hospital there are no facilities, no training facility most of these trainings, these workshops they are only for focused in the primary healthcare’ (Female, Koinadugu, IDI-9).

It was also recommended that additional allowances should be made available for outreach clinics in hard to reach areas as they are having to traverse difficult terrains to get to the patients.

‘...one of the big problem we are getting is having access, particularly in hard to reach areas, for people to get to the health facility; government should ensure that incentives are given to health staff those people carrying out those activities’ (Male, Koinadugu, IDI-12)

Another recommendation was for the Government to introduce a loan scheme for health workers wherein goods and services can be easily accessed by health workers.

‘they should give us the right to go and take loan from government or from banks or from institutions to build our capacity, or even to even encourage our life styles’ (Male, Koinadugu, IDI-11)

Separation allowance

The introduction of ‘separation allowance’ should also be considered, especially for female health workers separated from their families. Some would like to relocate with their families but a number of factors should be addressed to make the transition easier. It was also recommended that the government should also consider providing financial support to health workers in rural posting for the first six months of the posting.

‘...and this is something I was trying to propagate that if you are going to send people out they need to have that separation allowance; because its 90% of nurses are females and most of them have families apart from the fact that they have to run two homes, you need to give them a separation allowance’ (Female, Western Area, IDI-23)

Accommodation

A major deterrent in the retention of health workers in rural postings is the lack of suitable accommodation.

‘Some nurses when they are transferred to the province they don’t have accommodation’ (Female, Western Area, IDI-13)

In some places accommodation is not available, even for senior cadre health professionals. Health workers are living in cramped accommodation; it was reported that up to 3 nurses sometimes share a room, a situation far from ideal and which sometimes leads to conflict. Combined with high workloads, this creates very poor working conditions.

‘In fact I know a Matron who is having housing problems now and she is always grumbling “I am going back to Freetown because I cannot stay there I don’t have somewhere to stay, comfortable place” so housing is the problem it is the number one problem’ (Female, Western Area, IDI-14)

‘Another recommendation whenever we are transferred, they should make sure that we have accommodation because for now proper accommodation; we have a dwelling house with three

different nurses; at times some of us want to come with our families...at times we have lots of quarrel, at times we have to mix, male and female’ (Female, Koinadugu, IDI-10)

Health workers also recommended that decent furnished staff accommodation should be provided in close proximity to the health facilities for safety reasons, when having to deal with medical emergencies outside working hours. It is normal for streets to be deserted at night in rural parts of Sierra Leone, and with no vehicle provided for health workers, female health workers in particular are put at risk getting to the health facilities outside of normal working hours.

‘Even for our housing facilities they should provide more quarters or if the quarters are not enough they should rent houses for nurses because most of us we should not be far away from the hospital because if you are far away and this is not city life; most of the time this place when you say 9, 10 o’clock at night everywhere is quiet; so if I am far away ...it will not be easy for me get up from my bed far away to come to this place when I am afraid, because nobody is going to accompany me, no vehicle will be sent to go and collect me’ (Female, Koinadugu, IDI-10)

‘.....provide accommodation for them within the periphery of the hospital so they are just a stone’s throw from the hospital because these are all the things that can make the staff always readily available’ (Male, Kenema, IDI-6)

‘...there are quarters that have been constructed that are dilapidated they are not in good condition...people are not happy to be there but the ones that are newly built or renovated people are happy to stay there, but the other ones they are very disgruntled because of the status and these things are the reasons why they may want to leave to come, to return back’ (Female, Western Area, IDI-20)

Health workers also reported discrimination in the allocation of available accommodation with foreign health workers given preference. Therefore to address this issue, suitable and adequate accommodation should be provided for health workers and unsuitable available accommodation should be renovated to meet living standards.

‘....when they have foreign staff come in even, if they are blacks like us they will provide accommodation, put all sort of thing in those accommodation for them; but you will be here, maybe you are more senior than them but they wouldn’t provide for you’.’ (Female, Koinadugu, IDI-8)

It was also recommended that housing allowance should be paid to health workers not provided with staff accommodation.

‘For staffs who are not housed in government quarters or community structures, accommodation allowances need to be paid to them’ (Male, Kenema, IDI-5)

Mobility and communication

Health workers in rural postings, especially those in the hard to reach areas, are faced with the additional burden of dealing with transportation and communication constraints. Communication is a challenge due to lack of adequate mobile phone coverage. Health workers reported having to personally fund transportation in and around their working perimeter due to lack of transport provision in the health facilities. In addition they have to fund attending workshops in Freetown, as required by the job, from their salaries.

'First you have to think of their transportation, you have to think of the remoteness of the place. Each time they call them to come to workshops, to come to headquarters for meetings and so forth they have to you know the distance. There are some of my colleagues who can pay not less than 100,000 Leones [approximately £15/\$23], to come one way...[...].and this is coming from your pocket. So it is really too bad' (Male, Bonthe, IDI-3)

Female health workers are concerned about their safety travelling late. Some operations are performed out of working hours, meaning on call staff who have gone home for the day have to get back to the health facilities on their own as there is no available transportation system. An ambulance should also be provided for the health facilities ensuring that patients needing medical care are transported in the health facilities in a safe and controlled manner.

'...Kenema now we have so many new areas that are not very 'motorable' and then late at night after seven or eight pm the workers are even afraid to go home, they don't want to be late in the street because there is darkness all over the place[due to lack of electricity] and you know bad people will hang around where there is darkness. And so if we have transport collecting them and at point and taking them back after work to certain point I believe that will ease a lot of things. Now we have we need people to work in the operating theatres but they are living far away, when they are on night duties its ok. But then if we need to call others, let's say we have one or two accidents cases and we need help people who have gone home, we can hardly bring them after 10 at the night because they are afraid to take these okadas [commercial motorbikes] and so on and so forth. These are all the things. So we begin to think now can we provide accommodation for them within the periphery of the hospital so they are just a stone's throw from the hospital because these are all the things that can make the staff always readily available' (Male, Kenema, IDI-6)

It was also recommended that the Government should provide transportation for newly posted health workers to move to their posted locations as otherwise health workers have to arrange their personal transportation, which can be expensive and time consuming. This would also partly address the issue of health workers not reporting for duty in rural areas.

'My recommendation whenever we are transferred most of us we have family, we should be provided with a vehicle to take us along, because that is another problem. They should provide with vehicle to come with our belongings, for it is not easy for us; maybe we take about two to three times going to Freetown before we will be able to transfer all our belongings to this place' (Female, Koinadugu, IDI-10)

Social amenities

Provision of social amenities in the form of satellite TV, internet services and electricity (generator or solar lights) will serve as an additional incentive for health workers in rural areas and making them feel less disconnected from urbanisation. In addition it was reported that lack of schools in these areas discourages health workers from relocating with their families.

'Some family may decide to go with the wife and the children, but if there are no secondary schools...' (Female, Western Area, IDI-20)

Training opportunities

With any career, professional development and capacity building should be acquired. Health workers in rural areas feel discriminated against with regards to scholarships and training opportunities, both locally and internationally. Therefore the issue of regional disparities should be addressed to ensure health workers across the board have equal access to training opportunities. It was also reported that training opportunities are not made equally available even within the same region, with health workers in rural hospitals reporting that training opportunities are more in the PHUs are more compared to those available in the hospitals.

‘Above all staff capacity building, staff training; opportunity should be created for staff to upgrade themselves, the form of giving them scholarships’ (Male, Kenema, IDI-5)

‘Another thing, they should, we should be motivated by sending some of us to go and studies, giving us scholarships. But what we find out most of us who are working up in this, in the provinces we are neglected..[.]...MOHS, when they say they have scholarship for people to go and do short term courses for 2 and 3 months they should not only consider the Western Area..[.]... when these programs are around they should encourage us by choosing and say “let’s thinks about those up in the provinces”. But they are not considering us only those in the Western Area’ (Female, Koinadugu, IDI-10)

It was recommended that training opportunities should be prioritised; low levels of staff working in the communities should be encouraged to gain further education and mid-level cadre health professionals should be trained to act as first response units where higher cadres are not readily available. These measures will help facilitate career progression.

‘We want to be trained specially, we have CHOs that could want to be a pediatrics assistants, we have CHOs who want to be medical assistants, physicians, we want CHOs to be surgeon assistants, so where the doctors cannot go the CHO can go there and do it at community level, that is what we are yearning for’ (Male, Koinadugu, IDI-11)

‘There are people who serve as MCH aides in distant and most difficult communities for many years, but they have managed all by themselves without any help from government or so, so they have gone back to institutions to be trained as SECHNS, some are CHAs and others in more advanced levels. So I believe for those who are serving in those settings, if they are supported to come and upgrade themselves then and tagged to go back to those communities to serve some time, I think it will be helpful for the worker and for the country as a whole’ (Male, Kenema, IDI-4)

Improvement of working conditions

Health facilities have been neglected and have therefore created non-conducive working environments. Thus, it is recommended that health facilities should be improved in terms of the availability of drugs and functional equipment.

‘.....if there are more drugs the work will be easier; provide more drugs for these patients...[.]...everything they need in the hospital like bp machines, at least if that one is enough you have enough equipment you will be able to work’ (Female, Western Area, IDI-16)

The issue of overcrowding should also be addressed in rural health facilities. Health facilities should be adequately staffed, which will have a positive impact on health workers workload and ultimately their working conditions; it was reported that some PHUs in rural areas only have one health professional working there.

'Improve the facility I think that would be one [...]...the hospital environment should be clean, the wards or the wards should not be overcrowded...[...]...so that the patient have proper nursing care you see and the manpower, the staff there should be adequate number of staffs that I should be able to work with, I should not be deprived 'cause I cannot work alone' (Male, Western Area, IDI-18)

'Yes because some PHU only have one staff, it is very boring for one staff to run a facility 24 hours 7 days in a week' (Male, Kenema, IDI-5)

Uniforms should be provided for health workers to ease any potential additional financial burden in acquiring uniforms on their own.

General recommendations for an improved health system

Additional recommendations not specific for rural postings, were given to improve the overall health care delivery system in Sierra Leone. These included devolving responsibility to district level and recruiting and training more health workers. Creating a governing body for CHOs was again requested. It was also recommended that a new and improved welfare system should be implemented for health workers.

Devolve responsibility at district level

It was recommended that responsibilities for staff recruitment, training and retention should be governed at the district level without any interference at national level.

'We say districts operate on their own but is not 100% because when we say decentralization it has to be free hand; but you say decentralization but most of the things we go to national for it, or the council in a way they dictate so I don't know. Let everything be available here, so that the moment...[...]...since this interview is base on, staff recruitment, staff training let us have a hand in the recruitment as well. Let them allow us to choose whom we think is competent and let them think of reasonable number annually to be recruiting, because the previous number was so small' (Female, Koinadugu, IDI-8)

Creation of a governing body for CHOs

CHOs are calling on the Government of Sierra Leone to create a board to govern the affairs of training of CHOs and handle the performance monitoring of practicing CHOs. In addition, the training path for CHOs at paramedical schools should be handled by this proposed board in order to provide better quality assurance and control.

'And we [CHOs] also want a board that can really regulate our activities...[...]...We want the profession to be a noble profession...[...]... I want for government to ensure that the school of community health and sciences should be controlled by government. Before this time the CHO board or the CHO management used to manage the affairs of the paramedical school, but now since it came under the university we are having some CHO that were not really qualified...[...]...we are seeing

CHOs that cannot really perform, they are now on mass production; so we want in as much as the board has been set, to put things in perspective, to monitor admission and then the college activities until graduation, after which we really see what the CHOs can do' (Male ,Koinadugu, IDI-11)

'Up to today community health officers are practising without being monitored in this country. And it's a concern I have and a concern we all have in general' (Male, Koinadugu, IDI-12)

Train and recruit more staff

It was also recommended that health workers should be recruited promptly upon completion of their training course, ensuring that the expected financial remunerations are in place.

'...another issue that is a thorn in the flesh of the MOH is the delay in recruiting personnel who graduate from institutions. For example someone who graduates in March will work for one or two years as a volunteer before being absorbed. I am sure that in the medical field people need to be employed immediately they complete their course as otherwise the person will be working but will be lethargic; and those of us who are supervising them will not have the strength to really press that individual to do the work when we know that the individual is unsalaried. So prompt employment must be a must' (Male, Bonthe, IDI-2)

'Yes to fast track this recruitment process and even the payment of salaries is not just to recruit but to to fast track the payment as I was saying' (Female, Koinadugu, IDI-9)

This recommendation for training and recruiting more staff is in line with WHO guidelines.

'....according to WHO for every 2 million of your population we should have one medical school. We have a population of about 7million now with one medical school, it is grossly not enough so it means we need at least another 2 medical schools because we have seven million so if we have 3 medical schools at least we can be working around WHO basic requirement' (Male, Kenema, IDI-6)

Discussion and conclusions

The key challenges to achieving equitable accessible health services in Sierra Leone include an acute shortage of trained health professionals and a large difference in the available HRH in rural health facilities compared to urban facilities, especially among professional cadres (MacKinnon and MacLaren 2012). The Ministry of Health and Sanitation (MOHS) has made significant achievements in developing the health workforce in Sierra Leone. However, it is still plagued with inadequate human resources, poor skills mix, a de-motivated workforce and a high attrition rate (MOHS 2010). Research into underlying factors is therefore of continued relevance.

In this section, the themes that emerged from this study will be used to further elucidate the interrelationship between personal health worker factors, context factors and policy levers and their influence on human resource for health in general and the recommendations for a retention package for rural posted health workers, in relation to the conceptual framework. This study showed that in general the three arms of the framework are closely interlinked and played vital roles in influencing health workers to join the health work force and work and stay in hard to reach areas of Sierra Leone.

Many of the themes which emerged from the interviews were consistent with wider literature on health worker retention (Lehman, Dieleman, & Martineau 2008), although some aspects were specific to the Sierra Leone context.

Factors which attracted staff to enter the profession were shared with other contexts; respect for the profession, the influence of personal relationships and the availability of free courses for e.g. paramedics. This study highlighted that personal preference and motivation were important across a number of themes, including the decision to join the health work force. Family, including influential family members and financial situations, also played a role in the decision to join the health profession. Gender differences also were evident with regards to health workers who were influenced by family members to join the health profession. Female health workers were predominately influenced by members of their families to join the health profession, which was not evident in the male category. This might be due to the fact that nursing in those years was mostly perceived as a female profession. With regards to the family financial situation, male health workers were predominately influenced to join the profession due to lack of financial support and opted for the tuition free paramedical school. Female health workers decided to join the health profession if the main providers in their families had died, and opted for the then tuition free National School of Nursing. This entry route may not be so easy now that previously free training such as nursing and paramedical school now requires fees.

The level of national ownership for the initial training acquired by health professionals is high. Training was received from various training institutions in Sierra Leone and in some cases scholarships were awarded to pursue international studies. Of the health workers that participated in this study, these awards were given only to male health professionals to pursue higher degree programmes (e.g. medical degrees or to specialise) in countries outside the Africa region. Subsequent training undertaken in Sierra Leone was by predominately female health workers training to become midwives and in one case a male health worker retraining at the paramedical school. This is probably due to the female health workers preferring to undertake regionally available short courses and local courses to minimise the time they have to spend away from their families. It could also be that female health workers were only offered these courses and non-specialist courses, which is reflected in the current structure of the health service in Sierra Leone, where males dominate the high level positions.

In relation to recruitment, a number of complaints were expressed, including the lack of decentralisation and the need for bribes (at least in the past) to get on payroll. The role of 'volunteers' – staff working but not taken onto payroll due to delays in recruitment and enrolment – is pronounced, and causes problems of retention, though the situation was improved during recent payroll cleaning operations.

Another feature of the labour market which emerged from interviews, which seemed particular to Sierra Leone (perhaps more strongly in an earlier era), was the focus on public health and preventive work as the route to advancement in terms of training and career development. This may be being modified now as the country seeks to develop more specialist doctors.

Some gender themes were also apparent: the difficulty of being a male nurse, for example, and for women, the greater difficulty they faced liberating themselves from household roles to attend in-

service training. They also found the separation from family when posted to rural areas harder, and reported more commonly concerns about transport and security when travelling in those areas.

Rural health workers face particular challenges in Sierra Leone, some of which stem from the difficult terrain, with riverine and other barriers which add to common disadvantages of rural living (poor social amenities etc.). Poor working conditions, emotional and financial costs of separation from families, limited access to training, longer working hours (due to staff shortages) and the inability to earn from other sources make working in rural areas less attractive. Moreover, rules on rotation which should protect staff from being left too long in rural areas are not reported to be respected.

By contrast, poor management was a theme with more resonance in urban areas, with reports of poor delegation, favouritism, and a lack of autonomy for staff. Tensions within the team over unclear roles, absenteeism etc are also significant demotivating factors in general. It is also interesting that the monitoring and evaluation roles, which were reinforced as part of the FHCI, create some professional irritation (with health staff resenting felt that they were unwarrantedly 'supervised' by unqualified community members). These can include members of civil societies, village health committees, 'mammy queens' who are female heads of society or other members of the community.

Some issues raised were specific to one cadre. The CHOs felt most strongly that career progression was not built into their role and that they were not well represented at national level by a regulatory body, unlike other cadres (represented by the Sierra Leone Nursing and Midwifery board, Sierra Leone Medical and Dental Council and the Pharmacy Board), which would ensure respectability and recognition of their role.

Across all groups, the most important satisfier was feeling that you had made a positive impact and that you were effective in your role (which was especially true for staff at community level). This lies within the 'context factors' domain of the conceptual framework and is in line with the literature. There was also recognition that pay and working conditions have improved in Sierra Leone, which is also an important source of motivation.

In relation to financial incentives, salaries are clearly the most important and reliable element, and the recent substantial pay increase is appreciated, though there is still a sense that it is not adequate in relation to the cost of living. Other allowances are woeful in terms of reliability and regularity. Both the rural area allowance and the PBF payments are not received at all regularly by health workers. They have high hopes of PBF, as expressed in the quotes in this report, however these hopes have not yet been realised. Private business is an important source of supplementary income in Western Region. In rural areas, some reported gifts as being a significant part of their coping strategies.

Certain themes were expected to emerge from the interviews but did not. One of these was international migration. The expectation was that a number of the staff would have left Sierra Leone during the war, so that the issue of why they had returned could be discussed. However,, this was not a feature of our sample.

Looking at changes over time, one of the features mentioned repeatedly was the reduction in discipline and respect for hierarchy within the sector post-conflict. While some reported the health system as being poor pre-war and others as functioning well, there was a majority view that issues such as nepotism and political interference had got worse in recent years, which may be linked to the disruptive effects during and after the conflict. This was also reported in the key informant interviews (Bertone & Witter, 2013).

The perceived effects of conflict on health workers and the health system echo the ReBUILD research carried out in other contexts such as northern Uganda (Namakula and Witter, 2014). Health workers being targeted by the armed factions, being forced to work for the RUF, having to remove their uniforms for self-preservation, working in facilities which had become refugee centres, these are all themes which echo reported experiences there.

The biggest changes for health workers in the health system post-conflict have been decentralisation, improvements in the primary health system, and gradually improving working conditions, most especially affected by the FHCI in 2010. They see the FHCI as having increased their workload but also produced investments in facilities and services, even if these are sometimes under strain with the new demands. The related PBF programme has the potential to give them a sense of accomplishment but requires changes to its design and regularity to enable this to be realised.

The study has enabled rich insights into how health workers perceive their lives and careers in four areas of Sierra Leone. There are however of course limitations with the method used – particularly the limited numbers included in the in-depth interviews and the fact that we have focussed on understanding the story of those who stayed in the public sector, rather than tracing people who did not. Some of the limitations of the method will be overcome by triangulation with the other ReBUILD research tools.

Recommendations

1. The recruitment process for health workers in Sierra Leone is too centralised and sometimes causes inordinate delays, allowing local managers no role in staff selection and performance management. This should be addressed as part of the establishment of the new Health Service Commission, whose mandate is to recruit human resource for health. Decentralisation of the process might also reduce the time which is currently taken to engage new staff, something which causes demotivation and attrition.
2. A full package of measures should be introduced to address the rural/urban divide for health staff. These should go beyond the currently erratic RAA to include: specific tours of duty (e.g. two years), which are respected; preferential training access for those who are working in rural areas; and provision of housing close to facilities (especially for female staff, for security reasons)
3. Routes into the medical profession for those of low income should be encouraged as it is likely that these staff, especially if mid-level, will more easily be retained in rural areas.

4. The development of a career structure with options for progression in pay and responsibility for CHOs should be developed (e.g. through the Scheme of Service which is currently being developed for Health Workers in Sierra Leone).
5. The PBF scheme should be reformed so that payments are regular (monthly, rather than quarterly), paid on time, and transparent. It was clear that as well as the financial top-up, health workers appreciated getting feedback on their work in the form of an appraisal system, and a way of providing this in a supportive way should be built into the PBF process.
6. The issue of controlling political interference is more delicate but could be addressed through the new Health Service Commission as well as through organisational culture changes of a broader nature.
7. The RAA should be reviewed to establish the additional costs of living and working in rural areas. It is not just a motivation scheme but also needs to cover the extra costs which health workers face. Greater involvement in its design would also ensure that health workers understand how it is meant to operate.

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Appendix

Tools

Policies to attract and retain health workers in rural areas-a review of policy drivers, implementation and effectiveness in post-conflict Sierra Leone

In-depth Interview Guide

Objectives: To explore health workers' and health managers' perceptions and experiences of the implementation of retention policies post-conflict.

- A. Introduce the purpose of the study – its aims and scope
- Assure participant of confidentiality and how it will be maintained
 - As for their consent to participate

B. Note details of participant.

1. Interviewee ID		6. Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
2. Date of Interview		7. Age	
3. Name of RHs or HCs		8. # of children	
4. Province		9. Family members	
5. Title interviewee		10. Education	

Questions

I would like to understand about your life. Can you draw me a line, starting from birth and leading to the present day? What are the major events that you would put on it? Describe them to me.

As respondent starts to draw, follow the story with probing questions such as:

- *When was that?*
- *Why did you do that?*
- *What did you enjoy about that?*
- *How did you manage in that situation?*
- *Where did you go next?*

Open-ended questions to provoke discussion:

1. Tell me a bit about yourself? How did you come to work in the health field?
2. What kinds of jobs have you done in the past?
3. How did you get this job?
4. Describe what you do now
5. How long have you been working here?
6. How do you feel about your current job?
7. *What do you like and dislike about it?*
8. Are you planning to stay? What are your plans for your future career?
9. Do you do other jobs as well, or other activities to make money? Tell me about them
10. Tell me about the different kinds of pay which you receive (probe: salary; allowances; user fees; payments from patients; incentives for deliveries; private business etc.).
 - a. Which ones are most valuable for you?
 - b. Why?
 - c. How do they change the way you work?
11. What are the main challenges you face in your professional life?
 - a. How do you cope with them?
12. What sort of changes have you seen over your period of working?
13. Do you know about any policies to encourage health workers to stay in rural areas? Tell me about them
 - a. Have they worked?
 - b. What do you think about them?
14. What do you think is the most important thing for the government to do to get health workers to work and stay in rural areas?

Coding framework

THEMES	SUB-THEMES
1. Decision to join the medical profession	<ul style="list-style-type: none"> 1.1 Individuals who influenced decision to become a health worker (personal, family or other) 1.2 Factors influencing decision to become a health worker <ul style="list-style-type: none"> 1.2.1 Respect for the profession in society 1.2.2 Availability of funding 1.2.3 Other
2. Training	<ul style="list-style-type: none"> 2.1 Initial training <ul style="list-style-type: none"> 2.1.1 Location of training 2.1.2 Length of initial training 2.1.3 Source of funding 2.1.4 Experience of training 2.1.5 Reasons for returning home) 2.2 Subsequent training/up-grading <ul style="list-style-type: none"> 2.2.1 Reasons for subsequent training 2.2.2 Location(s) for subsequent training 2.2.3 Source of funding 2.2.4 Length of subsequent 2.2.5 Experience of subsequent training 2.2.6 Reasons for returning to work to home after the training
3. Career trajectory	<ul style="list-style-type: none"> 3.1 Job description 3.2 Reason for job change <ul style="list-style-type: none"> 3.3.1 Self develop 3.3.2 Posting 3.3.3 Conflict 3.3.4 Family reasons 3.3 Future career plans <ul style="list-style-type: none"> 3.3.1 Reasons for career plan
4. Overall perception of career	<ul style="list-style-type: none"> 4.1 Satisfaction 4.2 Dissatisfaction 4.3 Motivating factors <ul style="list-style-type: none"> 4.3.1 Religion 4.3.2 Community service 4.3.3 Satisfaction about role 4.3.4 Financial incentives (salary and allowances) 4.3.5 Working conditions 4.3.6 Level of Autonomy 4.4 De-motivating factors <ul style="list-style-type: none"> 4.4.1 Professional relationships (with colleagues and superiors) 4.4.2 Level of Autonomy 4.4.3 Political interference 4.4.4 Relationship with communities 4.4.5 Security 4.4.6 Separation of family 4.4.7 Limited opportunities for training (regional disparities)

5. International migration	5.1 Factors for migrating 5.2 Reasons for coming back
6. Context of conflict	6.1 Pre conflict 6.1.1 Health workers 6.1.2 Health system 6.1.3 Coping strategies 6.2 Situation during the conflict 6.2.1 Effect on Health workers 6.2.2 Effect on Health system 6.2.3 Coping strategies 6.3 Post conflict situation 6.3.1 Health workers 6.3.2 Health system 6.3.3 Coping strategies
7. Sources of income	7.1 Salary 7.2 Allowances (PBF, RAA) 7.3 User fees 7.4 Gifts from patients 7.5 Private business 7.6 Other sources of income
8. Experiences and perception of Incentive policies	8.1 Incentive policies experienced/heard of 8.2 FHCI 8.2.1 Personal effects 8.2.2 Health system effects 8.3 RAA 8.3.1 Personal effects 8.3.2 Health system effects 8.4 PBF 8.4.1 Personal effects 8.4.2 Health system effects 8.5 Salary uplift 8.5.1 Personal effects 8.5.2 Health system effects 8.6 Other 8.6.1 Personal effects 8.6.2 Health system effects
9. Recommendations for a retention package for rural and hard to reach areas	
10. General recommendations	