



The development of HRH policy in Sierra Leone, 2002-2012 – report on key informant interviews

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Executive Summary

Introduction and objectives

The ReBUILD Project 2 in Sierra Leone focuses on Human Resources for Health (HRH), in particular the incentives established for health workers (HWs) and how they have changed since the conflict. The ReBUILD Consortium conducted a document review that helped to identify gaps in available information on HRH policy-making and formulate hypotheses. The key informant interviews detailed in this document aim to build on the document review by filling these gaps with the insights of the actors involved in policy-making in Sierra Leone. The analysis in this report intends to investigate the key informants' narrative of the sequence of the events, as well as to explore some of the factors that defined the decision-making process in the post-conflict period.

Research methods

23 key informants were interviewed. 12 of the interviewees work or worked at the Ministry of Health and Sanitation (MoHS) or in other governmental agencies. Additionally, 6 NGO representatives, 4 donor representatives and 1 Technical Assistant (TA) were interviewed. Interviews were analyzed using thematic coding. The initial list of themes forms the backbone around which this report is structured. Examining each of the challenges and policy responses in turn, the report is ordered chronologically. Interviews were triangulated with the documentary review. Any similarities and discrepancies were analysed in a reflexive way to understand why the perceptions of the participants differed or otherwise from the reviewed documentation.

Findings

HRH context and challenges during and in the aftermath of the crisis

The few interviewees who could recall the period immediately after the conflict described it as challenging for the health system. Most services were completely disrupted and many of the HWs left the country, particularly those in the higher cadres. Other HWs worked for NGOs or held dual positions with NGOs and the MoHS. In this period, a lack of coordination between the different actors of the health system appeared to be an important feature of the policy context. Individual NGOs and donors were acting independently, setting up their own facilities or rehabilitating existing ones, as well as recruiting and remunerating HWs directly.

HRH policies and measures in the immediate post-conflict phase

The reconstruction process started soon after the end of the war (2002) and overall, the MoHS was able to maintain leadership during this period.

Integrating the informal workforce: After signing the peace agreement, it was decided that 'combat medics' (i.e., untrained personnel working behind the rebel lines) needed to be reintegrated and retrained as 'vaccinators', which proved a useful solution to cope with the lack of personnel for basic services. Similarly, the utilisation of volunteers for primary healthcare services provided some relief to overstretched HWs. Formalising and improving the existing informal workforce was an essential initial step for health systems strengthening in Sierra Leone.

HRH policy-making: 2002-2009: Despite these practical solutions, from 2002-2009 progress in policy-making for the restructure the health workforce was slow. Problems were identified by the MoHS but until 2009, little progress was made. This is likely to be attributable to a lack of clear political vision on the future of the health system.

The broader political context also played an important role as the first government elected after the war was weak in terms of leadership and drive for reform. A series of policies were drafted with the involvement of international agencies and external technical assistance. Rather than become effective strategies to be implemented at peripheral level, they stayed 'on paper'. The consequence was a relatively static approach, which left little room for innovation and focused mostly on policy 'fire-fighting'.

Introduction of the Free Health Care Initiative and related HRH reforms: 2009-2010

A major event that respondents consistently mentioned in their narratives was the introduction of the Free Health Care Initiative (FHCI) in early 2010. The preparation and launch of the FHCI appears to be the defining moment that shaped the healthcare system and gave a strategic approach to HRH policies.

Drivers of change for the introduction of the FHCI: Most of the respondents recognised the key role of the President as a driver of this reform. Other respondents highlighted the very high maternal mortality rates in Sierra Leone and the financial barriers to access to services. The international context and the popularity of this reform among donors was also mentioned as an important factor.

Consequences of the launch of FHCI: While the impact of the FHCI on the health of the population is under evaluation, it is clear that the launch of the policy had important effects on the health system and its organisation. Above all, the FHCI provided the opportunity to address the issues that previously were partially solved with piecemeal reforms and to strengthen the health system as a whole. It was also an occasion to improve coordination among actors. The announcement of the FHCI created a momentum for collective action and renewed partnership between the different stakeholders in the health sector. However, beyond the FHCI preparatory period, this collaboration between the MoHS and partners seemed to diminish.

HRH changes introduced in preparation for the FHCI

Policy objectives and approaches: The introduction of the FHCI played an instrumental role in pushing new policies and reforms to address HRH issues. HW salaries were increased to be representative of their increased workload and the fact that they could no longer charge informal fees. The need for 'payroll cleaning' was recognised by both MoHS and development partners as it ensured that the HWs being paid really existed. Donors wanted to eliminate 'ghost workers' and free financial resources, as well as protect their investment and minimize fiduciary risk. The 'Sanctions Framework' to reduce HWs absenteeism was also introduced in January 2011. Finally, in order to increase the number of HWs in the short-term, a temporary mobile recruitment programme was introduced at district level.

Issues and challenges in the decision-making process: The decision-making process that led to the selection, design and implementation of these reforms was less smooth than it would appear from the end result. The following issues emerged during the interviews:

- (i) **The sense of urgency and rush to prepare the reform.** This did not allow time to thoroughly analyse problems and potential solutions, which led to frustration for some actors;
- (ii) **The Technical Assistants (TA) that were involved in the process.** The lack of coordination between the large number of external consultants led to incoherence in the decision-making processes. It also resulted in duplication of work and a loss of institutional memory;
- (iii) **Conflicting donors' agendas,** in particular around the merits of a salary increase compared to a performance-based financing (PBF) scheme. Moreover, the MoHS seemed to be caught in the cross-fire between donors, resulting in fragmented policies and strategies. In addition, focus was given to the immediate design of the policies rather than the implementation, which appeared to be even more fragmented and ineffective.

HRH policies and measures: 2010-2012 **Performance-based financing**

The introduction of a Performance-based Financing (PBF) scheme had been discussed during the preparation of the FHCI, but then put aside in favour of a salary increase. However, the MoHS and development partners (World Bank) remained interested in the idea and PBF was implemented one year after the start of the FHCI.

Policy objectives and approaches: Most respondents recognised that the objective of the PBF scheme was to address HRH issues by providing an incentive for HWs, rather than to provide funds for facilities' running costs and investments. 40% of the payment must be used for the facility and 60% is divided among staff.

Drivers of change for PBF: There was no single issue that emerged as the main driver for the introduction of PBF. Many respondents noted that the introduction of PBF was led by the World Bank, the main funder of the scheme, while the other development partners were less engaged (if not openly opposed). Within the MoHS, it is interesting to note the division of 'tasks' between Department for Planning and Information (DPI) who had responsibility for the PBF scheme (World Bank funded) and the Directorate for HRH, who were responsible for the salary increase, payroll clean and Sanctions Framework (DfID funded).

Implementation of PBF scheme: PBF was implemented immediately at national-level, covering all primary health units (PHUs). The scheme faced some challenges:

- (i) ensuring the understanding and acceptance of a new concept (i.e., performance-based),
- (ii) ensuring the smooth set-up and operation of the scheme, particularly in relation to the flow of funds,
- (iii) ensuring correct reporting and record keeping. These challenges led to extremely long delays in the payment of PBF bonuses to health facilities.

Remote allowance

Plans for the introduction of a remote allowance were initially discussed during the preparation for the FHCI in 2009. However, this was not introduced until 2012, with the financial support of the Global Fund. Many respondents stated that the remote allowance rarely reached the HWs that are eligible for it, and that the scheme has generally been poorly implemented. Participants were lacking awareness about the function of, and sometimes even the existence of, the allowance.

Remaining HRH challenges

There has undoubtedly been important progress in HRH policies in Sierra Leone, particularly since 2010. However, reforms are seen as partial and some issues remain unresolved:

- (i) **Recruitment and deployment of HWs.** To cope with the immediate effects of the FHCI, a temporary mobile recruitment programme was launched as a one-off exercise at district level. At the same time, the establishment of a Health Service Commission (HSC) was planned to replace the Public Service Commission (PSC) and the Human Resources Management Office (HRMO). Despite the HSC being established by a Governmental Act in 2011 and the Commissioners being nominated, as of March 2013 the HSC appears to non-functional. HRH recruitment and deployment remains a highly centralized, lengthy and bureaucratic procedure;
- (ii) **Training of HWs.** Training, and in particular pre-service training, has been overlooked in Sierra Leone. The launch of the FHCI shifted the focus towards the quantity of HWs available rather than their quality.

- (iii) **Non-financial incentives for HWs.** The poor working conditions for HWs, particularly those in rural areas, was also found to have been overlooked in the HRH reforms. Factors such as transport and housing are recognized as key motivating factors for HWs.

Other themes related to the 'post-conflict' context

Most of the respondents did not refer to the post-conflict context to explain the development of policies. In fact, most respondents were not comfortable with the term 'post-conflict' as 10 years have passed since the end of the conflict. This left the researchers with the task of unravelling possible themes with reference to the 'post-conflict' context. The following elements were identified:

- (i) **Inadequate management capacity and skills.** Only one respondent mentioned a lack of expertise as a possible cause for the slowness of the reform process. However, another interviewee thought some of the officers at the MoHS had the skills needed to drive the reforms. The limited number of capable staff, rather than their skills, represented the key capacity problem;
- (ii) **Contracting-out of service delivery.** A number of post-conflict countries have started contracting-out health service delivery to external actors (usually international NGOs). In contrast, services have continuously been provided by the MoHS in Sierra Leone.
- (iii) **Decentralisation.** The literature highlights a pattern in post-conflict settings whereby the government tends to re-centralize decision-making and the implementation of policies to restore its power and legitimacy. In Sierra Leone, the MoHS maintained control over the development and management of policy reforms. However, because of the distance from the field, implementation was less effective than it would have been if left to the Council or to the District Health Management Teams (DHMTs) as envisaged by the Local Government Act of 1994.

Lessons and conclusions

How policies developed: Analysis of the key informant interviews confirms the same main phases in HRH policy-making as discussed in the document review. It also shows that the process is less linear than what it appeared from the documents alone.

The initial post-conflict period was critical to define the trajectory of health system reconstruction and to determine the shape of the system in place. However, efforts to tackle HRH issues were mostly limited to 'fire-fighting' to address the most pressing issues. In early 2010, the FHCI was launched. The FHCI played an instrumental role in pushing HRH issues much higher on the political agenda, both within the MoHS as well as among donors. As a result, a wave of HRH-related reforms followed. These reforms are usually defined as relatively successful in terms of addressing the HRH issues, but, some issues remained:

- (i) much attention was generated around the design of the policies, while far less focus was given to the implementation and to how policies were translated into practice at facility level;
- (ii) preference was often given to one-off exercises, such as the mobile recruitment, or shorter-term, practical solutions, rather than organic and coherent reform package;
- (iii) despite the increasing the alignment between partners and ministerial policies, there appears to be some disconnections between the different actors. The difference of views and agendas and the lack of coordination became problematic especially as the political pressure for rapid reforms was reduced, leaving room for fragmented policy-making and ineffective policy implementation. After launch of the FHCI, the pace of HRH decision-making and reforms slowed down and became patchier.

The country's conflict and post-conflict trajectory – its legacy and lessons for the future

A broader health financing reform as an entry point for HRH changes: The pattern of reform for HRH that is described for Sierra Leone is not uncommon to other contexts, whether post-conflict or not. The most salient moment in this trajectory is the introduction of a broader health financing reform, the FHCI. This reform was not focused on HRH, but had a critical impact on HRH and was instrumental to HRH reform. Indeed, experience across countries seems to show that there is the need for a broader healthcare financing reform as an entry point to successfully push new HRH policies.

Although the literature refers to a 'post-conflict window of opportunity', it is difficult to claim that in the case of Sierra Leone the opportunity for reform was exclusively linked to the post-conflict situation, also because of its timing much later after the end of the conflict. However, some elements that are typical of a post-conflict context facilitated this process. The fluidity of power relations and dynamics between influential actors could be one of the possible post-conflict characteristics that would facilitate reform (as for example, the non-opposition of the Professional Boards to the HRH reforms).

The 'narrative of success': Despite the lack of formal evaluations, it is also considered that the HRH reforms introduced with the FHCI were successful in addressing some of the more pressing HRH issues. Indeed, a sort of 'narrative of success' emerged in interviews, especially among actors at central level. While this narrative may partially reflect the truth, it could be also instrumental to signal the distance from the conflict and the immediate post-conflict period. It is also counterbalanced by the analysis of the challenges that remain, particularly at local level.

1. Introduction

Background to the overall research of ReBUILD - Project 2 in Sierra Leone

The ReBUILD Project 2 in Sierra Leone focuses on Human Resources for Health (HRH), in particular the incentives offered to HWs and how they have changed over the post-conflict period.

One of the most important components of a health system is the availability of adequate and skilled human resources (WHO, 2006). Paying and motivating HWs is as important as ensuring that there are enough HRH to provide healthcare services. The commitment and performance of the health workforce depends on several factors including but not limited to: conditions of service, continuing professional development, exposure to an enabling working environment and the provision of incentives. HW incentives are critical to the effective delivery of sustainable, accessible, equitable and affordable health care. With insufficient or no incentives HWs may e.g. refuse to work in rural areas as they may not be able to earn additional income from private practice or other sources. This could seriously affect the overall effectiveness of the health system, particularly in remote areas of the country.

As indicated in our research proposal (ReBUILD & COMAHS, 2012), we have limited information on whether the incentives available to HWs in Sierra Leone are sufficient to motivate the health workforce and incite commitment to stay in their jobs. Therefore, research into HWs incentives can provide evidence that will guide policy makers in the recruitment and retention of staff. The work of ReBUILD Project 2 can also inform the MoHS how to attract staff into new contracts, particularly in hard to reach areas.

The overall purpose of the study is *“to understand the post-conflict dynamics for HWs and ultimately how to reach and maintain incentive environments for HWs to support access to rational and equitable health services”* (ReBUILD & COMAHS, 2012: 6).

The specific objectives include:

- To document how the incentive environment has evolved since the conflict;
- To understand what influenced the policy trajectory;
- To describe HRH reform objectives and any intended and unintended effects seen as a result of these reforms; and
- To document lessons learned (on design, implementation, sustainability and suitability to context) and how they can be used to guide future interventions.

The methodology for the overall research of ReBUILD Project 2 is a retrospective, cross-sectional study using both quantitative and qualitative research methods. The timeframe for retrospective data collection covers 2002 (the end of the conflict) to the present day (2012). The overall study uses a variety of different methods and data collection tools. They include:

- stakeholder mapping -- carried out in Freetown in October 2012 (Witter, Kosia, & Samai, 2012)
- document review (Bertone, Witter, & Samai, 2013)
- key informant interviews, which this document reports on
- analysis of existing routine Health Management Information System (HMIS) data
- in-depth interviews/life histories of HWs
- quantitative HW incentive survey (HWIS)

Objectives of the key informant interviews

This document reports the findings of a series of key informant interviews with HWs.

The interviews build upon a document review carried out by the ReBuild project (Bertone et al., 2013). This review examines the development of HRH policies in Sierra Leone from 2002 to 2012 through the analysis of documents and written records. The document review identified gaps in information available on HRH policy-making. It also led to a series of hypotheses being proposed as to the possible factors that influenced HRH policy in Sierra Leone.

The key informant interviews analysed in this report aim to fill these information gaps. We will also triangulate our interview data with that of the document review to test and verify our hypotheses. The interviews will enable us to explore the perspectives of different actors, as well further our understanding of factors that defined the decision-making process, both of which may not have been recorded in written documents.

2. Research methods

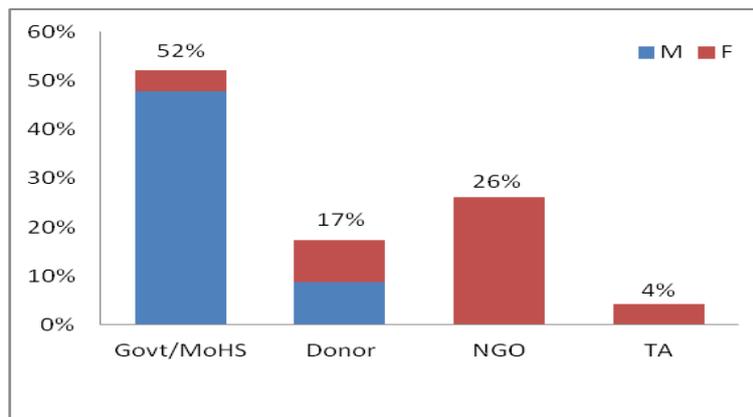
Key informants selected and interviewed

A preliminary list of relevant key informants was drafted by the ReBUILD team in Sierra Leone. This list included both national and international organisations as well as individuals. Subsequently, a snow-balling technique was used to identify further informants, based on the suggestions of those who had already been interviewed. Respondents who were unavailable for interview were substituted with others belonging to the same type of organisation (e.g., same Directorate in the MoHS, same donor organisation etc.).

23 key informants were interviewed between October 2012 and June 2013. Most of the interviews (19) were carried out in Freetown, whilst 2 were conducted at district level. The remaining interviews (2) were done outside of Sierra Leone or by telephone. 12 of the interviewees work or worked at the MoHS or with other governmental agencies. 6 NGO representatives were interviewed, along with 4 donor representatives and 1 Technical Assistant (TA). The graph below shows the key informants included in the sample.

One researcher carried out the majority of the interviews and 2 additional researchers assisted them for 5 of the interviews.

Figure 1: summary of characteristics of key informants interviewed



A topic guide was prepared for use across all of the ReBUILD project countries and then it was adapted for use in Sierra Leone. The questions were sequenced in chronological order. Participants were asked about the HRH context in the immediate post-conflict period and the challenges that they faced. They were then asked about the policy responses to these challenges and what effects these had on the health system. Finally, they were asked to share any lessons learned from their experience and whether they had any recommendations for the future.

The interviews were semi-structured and the tool was continuously adapted to further explore emerging themes.

Thematic analysis

Interviews were recorded and transcribed for thematic analysis, which was carried out by one researcher. The researcher became familiarized with the data to identify any emerging themes and then the interviews were analysed using thematic coding. Themes were charted to highlight pattern

in the responses to allow interpretation. The other members of the team provided feedback on the initial results of the analysis and on the draft of the report.

An initial list of themes for the thematic analysis was drafted based on the findings of the document review (Bertone et al., 2013) and further themes were added based on the interview data analysis. The themes are summarised in table 1.

Table 1: Themes and subthemes initially identified and used for thematic analysis

Themes	Subthemes	
HRH context and challenges	Recruitment challenges	Changes to these challenges since 2002
	Distribution challenges	
	Retention challenges	
	Performance challenges (pay, motivation, management, etc.)	
Policy responses	Policy objectives and approaches	For each of the policy responses
	Drivers of change	
	Implementation of policies	
	Financing of policies	
	Impacts	

This list forms the backbone around which the writing up of this report is structured. Looking at each of the challenges and of the policy responses in turn, the report mainly follows the chronological ordering of the events. Issues and themes that recur across time are highlighted and further analyzed.

Triangulation of information

The key informant interviews were triangulated with information from the documentary review. Firstly, the findings from the documentary review informed the topic guide structure. For example, as the FHCI had emerged as a key moment in policy development, care was taken not to explicitly mention it at any point during the interviews and rather let the respondent introduce and discuss it. Secondly, during the analysis of the interviews, findings were triangulated with those from the documentary review to further understand why the perceptions of actors differ or do not differ from what is recorded in the documentation. Information was triangulated not only between methods, but also between different sources, i.e. by comparing the responses of different actors on the same issue or question.

These methodologies are complementary and helpful in improving our understanding of the processes of policy-making and the perspectives of different actors.

Study limitations

The limitations and the potential for bias in our methodology and sampling is highlighted in this section.

The majority of the respondents (over half of them) were from the MoHS or from other governmental bodies. The remaining participants were donors, NGOs or Technical Assistants. Representatives from the MoHS were oversampled because it was easier to contact and obtain meetings with MoHS staff over donors and NGOs. Secondly, among donors, NGOs and TAs, there is a high staff turnover and few have been in Sierra Leone long enough to recall the main stages of the

policy-making process. With a couple of exceptions, none of the NGO/donor representatives have been in country since the immediate post-conflict period (about 2002) and many arrived after the introduction of the FCHI in 2010. To overcome this problem, 2 of the respondents were contacted and interviewed outside of Sierra Leone.

Similar bias was found towards MoHS documents included in the document review as these were the most readily available. This poses some limitations in triangulation as we have fewer documents and perspectives from outside of the government.

A second potential issue is the recall bias of the respondents. Since the period analysed spans over 10 years from 2002 to 2012, it was difficult to find respondents who were present in the country and engaged in HRH policy-making for that entire time. For those who were present, recalling the events that occurred in the initial post-conflict is not an easy task. Again, this problem is similar to that experienced in the documentary review as the majority of the documents analysed for that report had been written after 2010.

3. Findings

1.1 HRH context and challenges during and in the aftermath of the crisis

Obtaining narrative and insights into the HRH context in the immediate aftermath of the war was one of the main challenges of this research. Only some of the respondents were in Sierra Leone in 2000-2002. NGOs and international donors typically showed a shorter institutional memory and were less capable to recall earlier periods. Despite this, at least two of the expatriate personnel interviewed were in the country in or around 2000, while conversely some MoHS staff were absent at this time. Understandably, perspectives and insights on this early recovery period tend to be related closely to the interviewees' personal experiences, rather than that of their organisation¹.

Those interviewees who could recall the time after the conflict described it as very difficult for the health system. Most services were completely disrupted, particularly in the eastern and southern part of the country where most of the rebel activity took place. Many of the HWs left the country, especially those of higher cadres. Others worked for NGOs or held dual positions with the NGOs and the MoHS. Facilities were grossly understaffed and lacked the basic infrastructure to provide services to the population.

"It was horrible. The health personnel had migrated outside or were here but working for NGOs. There were critical shortages. They also had insufficient funds, so it took one and a half, two years to place people on the payroll. As a temporary measure, outsiders came to help." (8003, line 8 – MoHS).

"Most of this staff [...], some stayed and some went to other states in Africa and some went outside to Europe and America. So [...] immediately after the war we had a shortage of all health personnel in all the districts. I vividly remember I went to Kono immediately after the war and there was only one dispenser in Kono and there was nobody else, a dispenser and a dog." (9004, line 28 – MoHS).

The GoSL and MoHS had the difficult task of rebuilding the entire healthcare system, including the health workforce. In those early years, many respondents identified a lack of coordination between the different actors in the health system as an important feature of the policy context. NGOs and donors were acting independently, setting up their own facilities or rehabilitating existing ones. They also recruited and remunerated HWs directly, regardless of whether they were also included in the government payroll or not.

"During and immediately after the war, a lot of NGOs had entered the country and started on a kind of not very coordinated manner, to do all kinds of things everywhere." (9001, line 31 – NGO).

"What happened was, during a period of chaos, most of the NGOs were operating on their own. [...]. Early, in 2002, we had like 200 to 300 NGOs around the country, now we have 50 to 60". (9002, line 152 – MoHS).

1.2 HRH policies and measures in the immediate post-conflict phase

The recovery process started very soon after the end of the war in 2002. The conflict in Sierra Leone lasted approximately 11 years to varying degrees of intensity. Towards the final stages of the conflict, where negotiations were taking place and the intensity of the fighting and insecurity was diminishing, progress towards the reconstruction of the healthcare system were already being

¹ It is common, for example, for most of those who left Sierra Leone during the conflict to remember and report the exact date of their return to the country.

made. Overall, participants thought that the MoHS was able to maintain a certain leadership and managed to kickstart the reconstruction process. One respondent said:

“There was no staff [in the hospital], there was nothing left. It was just an empty shell and we completely re-established it between 2000, 2002, 2003. And then slowly the Ministry of Health started to come back [...] in very limited numbers, so we complemented that and it was, if you think about it, it was an interesting dynamic.” (9011, line 26 – NGO).

The direct involvement of the MoHS proved important in shaping the subsequent policy decisions on the restructuring of the health system (cf. par. 3.6 – Contracting-out of services).

3.2.1 Reintegrating the informal workforce and training new HWs

Interesting measures were introduced to provide an immediate response to the lack of health workers after the war. These measures arguably accelerated the reconstruction of the health system.

During the war, the rebel forces used ‘combat medics’, i.e. untrained personnel trained on-the-job to provide emergency services (including surgery) behind the rebel lines. During the last phases of the conflict, some collaboration between the combat medics and the MoHS in Freetown had already emerged. After the signing of the peace agreement, it was felt that the ‘medics’ needed to be reintegrated into civilian life. Some of them were therefore retrained as vaccinators. This proved to be a useful solution to cope with the lack of health personnel for basic services such as vaccination campaigns, particularly in the more unstable regions e.g. along the border with Guinea

An extensive network of volunteers was also used to provide primary healthcare services. Although often untrained or poorly trained, these volunteers were integrated into the payroll of the MoHS.

These measures provided some relief to the stretched health services in the immediate aftermath of the conflict. Formalising the informal workforce was also an essential step in health systems strengthening efforts. However, although the numbers of HWs in the facilities increased, the quality of the workforce decreased.

3.2.2 HRH policy-making: 2002-2009

Despite the implementation of these practical HRH solutions in the immediate aftermath of the war, from 2002-2009, restructuring the health workforce was much less rapid and effective. Challenges and solutions were being correctly identified and proposed by the MoHS (HRH Unit). However, little progress was made.

“I remember I had a PowerPoint presentation [on the HRH challenges and potential solutions] and then you would see the PowerPoint presentation every year with a little bit of adaptation [...]. You’d see the same PowerPoint presentation back with few changes [...]. But did you see anything change? That’s the thing, there was not much changing”. (9001, line 38-100 – NGO).

The reasons for the delays in the adoption and implementation of HRH policies could have been because of a lack of clear political vision on the future of the health system. Many key informants, belonging to different types of organisations, agreed that in the years following the conflict all strategic policies and plans were slow to be implemented or missing altogether.

“There was no policy and plan, or rather it was outdated and not based on evidence”. (8001, line 15 – MoHS).

“The main issue during this time [was that] the Human Resources strategic plan was not adequately addressing the issues of Human Resources. So because of the absence of a strategic plan, we were just swimming with ideas [...] and it was urgent that something needed to be done, you know, as there was no clear direction as to what to do.” (8007, line 491 – donor).

“Let me tell you something, in life when you do not have a goal you are working towards and you go purposeless, aimless, you’re slow at it”. (9009, line 539 – MoHS).

“[...] there were so many things to be done, after the war and, how do you know what is the best thing to start with and what should come after that and what should come after? And it's only once we got a National Health Strategic Plan [end of 2009] and a Compact and Joint Plan for Work and Funding [end of 2011 and beginning of 2012] that we got a much more structured, focused way of working”. (9001, line 807 – NGO).

As the respondents highlighted, the consequence of the lack of political guidance and strategic vision was a general sense of ‘purposelessness’. Decisions were on hold as no one was held accountable, and reforms were progressing slowly. This resonates with the findings from the documentary review, which found that in the first years after the conflict, *“reforms were rarely implemented and the response to the challenges remained fragmented - perhaps because of the fluid and uncertain policy context where even key actors did not seem to have control of the strategic decisions, as recognized by the HRH Development Plan 2004-2008 (“[...] the current level of uncertainty regarding the exact nature of the reforms [...]”), p. 80”* (Bertone et al., 2013: p.30).

The broader political dimension also played an important role in understanding the lack of strategic vision for the health sector. The first elections after the end of the war were held in 2002 and the elected government stayed in power until 2007. However, it is perceived that the first government was weak in terms of leadership and drive for reform, especially compared to the subsequent government in power from 2007.

“The government that was there in Sierra Leone just after the war was [...] a very weak government [...]. There was no trust in the government, there was still a big remnant of animosity towards the north of the country, for example, because of the dynamics during the war. So I think we shouldn’t underestimate that. I feel that the real changes only started when the new government came in. That’s 2007”. (9011, line 620 – NGO).

With reference to the policies that were developed in those years, the situation seems paradoxical and the perspectives of the respondents contradictory. Some respondents stated that before the FHCI there was very little interest (and correspondingly little funding and technical support) in Sierra Leone from international donors.

“Formerly, nobody was paying attention to Sierra Leone. They are, ‘ok, it is just one backward country’. I mean, nobody cares whether they have a goal or no goal. Nobody was looking at us. But with the free healthcare we became like a goldfish in an aquarium, everybody wanted to know what is happening in this country”. (9009, line 539 – MoHS).

Other respondents, particularly NGO representatives, pointed out that most of the policies were (and, to some extent, still are) externally-driven, lacking the national ownership that would ensure their effective implementation.

“People started working on their own areas and they started developing a policy and plan and things like that [...]. But I mean it was all happening in kind of parallel, also depending [...] on the focus of

donors to provide TA and funding for certain things. So I mean, I think a lot of policies applied at the beginning were definitely donor driven. Yeah, WHO said 'you don't have a policy on this and this. We have to develop it', and you'll get it." (9001, line 807 – NGO).

"There doesn't appear to be ownership at the ministry level. It, it feels like, it's UNICEF pushing it. UNICEF have obviously great links with the Ministry [...]" (9014, line 304 – NGO)

Some international organisations also confirmed their involvement and the important role that they played in the drafting of the policy documents.

"We are involved in all of this. Like, for the National Health Policy Strategic Plan, we were directly involved, in fact, we led the process. [...] Our mandate is actually in terms of development of policy and strategic plans, yes [...]. So we led those processes. We played an advocacy role [...]. We went beyond that, we brought in experts for example, consultants to help provide technical assistance with the Ministry. Sometimes a little bit of financial assistance was provided, especially starting the process." (9007, line 164 – donor).

A plausible explanation for these contrasting views is that certain policies were drafted with much involvement of international agencies. A lack of technical and implementation capacity, alongside the narrow focus of some of the agencies involved, may have resulted in these documents remaining official policies on paper, rather than effective strategies to be reflected at peripheral level. This also emerged in the documentary review, which noted that policy documents provided *"a relatively vague normative framework rather than an operational document"* (Bertone et al., 2013: p.14). Drafting this type of policies without an overarching vision resulted in relatively static approach, leaving little room for innovation and focusing efforts on "fire-fighting", i.e. tackling the most immediate issues with quick-fix solutions and practical measures.

This context substantially changed with the introduction of the FHCI.

1.3 Introduction of the Free Health Care Initiative and related HRH reforms: 2009-2010

The key event that respondents consistently mentioned in their interviews was the introduction of the FHCI in early 2010. The FHCI appears to be the defining moment that shaped the healthcare system and gave a strategic approach to HRH policies.

Since the FHCI had already emerged as a key event in the documentary review, the researcher did not explicitly mention it during the interviews. However, it is interesting to note that it was always introduced by the respondents themselves, who often used this event to begin their narratives or framed their narratives around 'before' and 'after' the FHCI. The quotes from the different actors illustrate their overall consensus on the importance of this event.

"What is a turning point, in the past 10 years, is the free health care. [...]. I believe, for the past 10 years, that free health care was a big turning point, because before gradually everything was coming up. The free health care was big turning point to accelerate the improvement". (9008, line 63 – donor).

"The introduction of the free health care put the system in place. For nurses, it meant the development of a series of documents, including the core competences, PBF, Sanction Framework, BPHCS, increase in salary, etc. So that things can be taken on from there and there can be aspiration for learning more. [...] The free health care was an eye opener." (9003, line 108 – MoHS).

"And don't forget, this free health care was the singular moment. I wonder which other moment we had for a complete sector wide approach at solving a national issue. Everybody was there, all NGOs,

donors, everybody came and everybody wanted to achieve this because the President was there, he said 'this is what I want'." (9009, line 539 – MoHS).

Although the introduction of the FHCI is rather a health financing reform than HRH policy *per se*, because of its impact of the HRH we explored this theme further with the respondents:

"To be honest with you, [the moment] when we had a lot of partners helping the Ministry in terms of human resource was when we had the free healthcare. That attracted a lot of partners. Before, many partners did not consider it [human resources] a priority per se." (9007, line 186 – donor).

Drivers of change for the introduction of the FHCI

In November 2009, President Ernest Bai Koroma, announced his intention to introduce free healthcare for pregnant and lactating women and children below 5 years of age². A short few months were given to prepare the launch of the initiative in April 2010. When asked about the reasons behind this decision, many of the respondents mentioned the role of the President himself and the lead that he took to include the FHCI among the government's priorities.

"It is a strong decision from the President. He announced it before discussion with a lot of partners" (9008, line 106 – donor).

"In November, we had a launching of the National Health Sector Strategic Plan [...], just after a big conference in the UK. And then he announced that in April we would have free healthcare [...]. It's really a higher level. I mean, he announced it. He came to launch the National Health Sector Strategic Plan and he came together with his Vice-Presidents and announced that we were going to get free healthcare". (9001, line 164 – NGO).

Other respondents highlighted the very high mortality rates in Sierra Leone and the financial barriers to accessing health services which made this decision necessary.

"It was a presidential initiative and so people were interested, that's one. Number two, there's been a cry for attention towards maternal and child mortality and for many, many years Sierra Leone was last in the human development index". (9007, line 525 – MoHS).

"Before [the FHCI] we actually did a survey together with [another NGO] and our finding was that money was a barrier for women and children to access the health service delivery. So we started a case to the government, together with other INGOs, for user fees to be removed for the care of women and children." (9013, line 32 – NGO).

Another factor that was mentioned was the international context. Free healthcare was at the time an increasingly popular reform in many other African countries, supported by many international donors.

"I think also possibility of getting funding and things like that, and there was pressure, yeah, from some of the partners, as far as I am aware." (9001, line 164 – NGO).

Other informants remembered the failed attempt of the previous government to introduce free healthcare for some categories of patients in 2002. Comparing this with the reform of 2010 helps identify the possible reasons for success of the latter, including the different international context and the external support available.

² The launch of the FHCI was announced at a donors meeting in September 2009 in London.

Interviewer: *“Why do you think that the free healthcare policy of 2002/2003 didn’t find that much support and failed, while in 2010...?”*

Respondent: *“Because of what happened in 2010. You have to have it in context. I know that there was a push in 2008/2009 by Gordon Brown and he decided, DfID decided to support [the reform]. And because of DfID support, [...] that is why it was able to get off. Under our government’s own resources they could not [support it].”* (9004, line 163 – MoHS).

Consequences of the launch of FHCI

Although the impact of the FHCI on the health of the population is still under evaluation, it is clear that the launch of the policy had important effects on the health system and its organisation. Above all, the launch of the FHCI provided an important opportunity for health systems strengthening and to address in a more comprehensive way the issues that previously were partially solved with piecemeal reforms. This was highlighted by partners and NGOs during the interviews.

“Having the free healthcare coming has helped the health system strengthening. I mean, of course, the National Health Sector Strategic Plan was written according to the six building blocks of WHO [...], but the free healthcare kind of pushed us to work more in that [sense]” (9001, line 816 – NGO).

“It’s a process, yeah. And that’s why some partners, I mean, I am part of them, think that this is an ideal opportunity for health system strengthening [...]”(9001, line 216 – NGO).

“Different components have fallen into place [with the FHCI], but it was bitty. Service delivery came first, and then it was followed by attempts to strengthen the health system, although it should have been done the other way around”. (8002, line 40 – donor).

The FHCI had some important spill-over effects in terms of the reforms introduced to address the most pressing HRH issues. These reforms are further analysed in section 3.3.1.

The FHCI also presented an occasion to improve the coordination between actors and to provide a broad, common objective to all stakeholders. In this sense, it is interesting to note that when discussing the FHCI most of the respondents focused on what was achieved during the design and preparation phases, rather than what was implemented. It appears that the announcement of the FHCI and the few months of intense preparation work created a momentum for collective action and renewed partnership between the different stakeholders in the health sector.

In preparation for the FHCI launch, six technical working groups were put in place, one of which focused specifically on HRH issues. These groups held their meetings up to once a week during preparation phase (November 2009 to April 2010). They were tasked with designing the reforms and changes in the health system necessary to ensure the smooth roll out of the FHCI. They also coordinated different partners, assigned roles and identified available funding. International partners viewed these working groups as ‘task force’ that guaranteed coordination and adequate planning of the reforms. In October 2011, the process was consolidated with the signature of a ‘Compact’ between the Government and partners under the International Health Partnership (IHP+) initiative. To facilitate this, the technical working groups were formalised and other coordinating groups were put in place, namely the Health Sector Coordinating Committee and the Health Sector Steering Group.

However, although the different inter-agency groups increased the coordination among actors in the health sector, some issues remained:

“Of course we had our Working Group meetings and we would talk, but these were the ‘big lines’. If you go to the little activities, we were not so well coordinated”. (9001, line 591– NGO).

In particular, the major donors had different views on the FHCI and how the health system should be reorganized to provide free health services. This is further explained in section 3.3.1.

“The capacity of the Ministry to coordinate was limited, but we were all, as partners, trying to push for the Ministry to take the lead and to appear to be in the lead” (9001, line 618 – NGO).

Also, within the MoHS there were some overlapping responsibilities. For HRH issues, two different Departments were involved in different parts of the reform, the DPI (Department for Planning and Information) and the Directorate for HRH. This fragmentation led to incoherent policies, inconsistent implementation and a lack of information sharing.

“You have many different programmes and directorates doing something on human resources in the Ministry [...]. We had people doing human resources from DPI, when actually it should have been the Directorate [of HRH].” (9001, line 313 – NGO).

The collaboration between Ministry and partners seemed diminished, if not lost, during the implementation phase of the FHCI. The working groups were reported to meet infrequently after the launch of the FHCI and were almost non-functional by the time the interviews were carried out (March 2013).

“And then later on, [the HRH Working Group] kind of went to sleep. There was a break when the new Director came in, and we started working on policy planning, with sometimes more frequent, sometimes less frequent meetings.” (9001, line 628 – NGO).

3.3.1 HRH changes introduced in preparation for the FHCI

The FHCI was not only a critical moment for the strategic coordination of the health sector but also to provide a common overarching vision for the health system. It also played an instrumental role in pushing new policies and reforms to address HRH issues. During the interviews, most stakeholders recognised that the FHCI made the MoHS address some of the issues affecting the health workforce. Reforms were needed for two reasons: to cope with the increased workload for HWs when services became free and to ensure the right incentives were in place so that HWs would provide services for free, rather than charge informal fees. As one respondent states, the MoHS and partners were very aware of these two potential consequences on HWs and their incentives:

“The government was very very clear on the problem. They understood that [the FHCI] will boost the demand for healthcare services and so then, of course, they would have to increase the number of health workers in the field. On that we didn’t have much to propose and basically the government had to do that quickly, so that was the first issue. The second issue was that this free care initiative would remove all user fees. From what I understand, user fees were already illegal but actually they were tolerated and they accounted for quite a big portion of the revenues of health workers, as they had very low salaries. So the issue was how do you replace this revenue? One solution was to increase the salaries and the other one was to introduce some PBF mechanism, which had the advantage of also improving the accountability of health workers [...]. There was a third issue related to the geographical distribution of health workers. As you know, most of them are located in Freetown so the idea with the free care initiative was also to set up an incentive package to ensure that some health workers would agree to go into rural areas.” (9017, line 7 – donor).

From this starting point, the technical working groups introduced a series of interrelated HRH reforms before the launch of the FHCI.

Policy objectives and approaches

In this section, we briefly outline the rationale behind the HRH policies that were adopted for the launch of the FHCI. Further details on the design, financing and impact of these reforms is provided in the documentary review (Bertone et al., 2013), including the quantitative information that is difficult to obtain from oral interviews. The description here intends to provide a background to the policy-making process that follows, which is difficult to understand in the written documents.

It was decided to substantially **increase the salary** of the HWs (please see the document review for specific salary information). The salary increase would provide HWs with the right incentives to deal with the increased workload and prevent them from charging informal fees. In the longer term, it would also help to increase the number of HWs available as more would find the career attractive.

“In the preparation towards the free healthcare, salaries were increased massively for health workers and for technical people in the sector and that really attracted a lot of medical practitioners to come on board, namely the doctors and nurses [...]. Those that went into the NGO sector came straight [back] to the public domain. It was a very good strategy that the government used”. (9010, line 26 – MoHS).

This salary increase required a precise knowledge of the number and qualification of HWs in the MoHS payroll. The **payroll clean** had to be carried out, as it was thought there were many ‘ghost workers’ that were wasting financial resources. The need for this was recognized both by MoHS officials and development partners who perceived this measure as necessary in order to “protect their investment”, so that the payments would not end up in the hands of non-existing or non-qualified workers.

The **‘Sanctions Framework’**, a mechanism to check on attendance and absenteeism and sanction the HWs accordingly, was also introduced from January 2011. A donor’s perspective onto this reform highlights how the reasons for the implementation of this policy were to protect their investment and minimize fiduciary risk.

“Looking over the period, there is a sequence of reforms all prompted by the free healthcare – which in turn triggered salary changes, and then reforms to protect those investments, such as tightening up on staff absenteeism. There was a need for us to minimise risks [...]”. (8002, line 40 – donor).

However, the introduction of the Sanction Framework also created the right incentives for the HWs, ensured their presence in the facilities and restored HW accountability.

In March 2010, some of the major ‘vertical programs’ decided to **stop extra payments** to HWs. In particular, the National HIV/AIDS Secretariat, whose funding to provide top-ups for HWs working on HIV decided to end these payments.

While the salary increase improved the number of HWs available in the long run, in the short term other solutions were necessary. A **mobile recruitment programme** was introduced at district level where a panel was responsible for interviewing and hiring health workers in the same districts where they would be assigned to work. As one respondent recalls, this process had two advantages; it increased the retention of HWs at district level as they were selected locally and not posted from the MoHS, and it helped to formally recruit all those who had been working in the facilities as ‘volunteers’ and were therefore not included in the MoHS payroll.

“To address recruitment problems, a district mobile recruitment programme was set up in all 13 districts. A mobile interview panel targeting MCH Aides, SRNs, CHAs/CHOs, midwives and cleaners moved around, seeking to recruit directly from the districts. At present, all recruitment is centralised and people are not able to express preferences for where they will be posted. By recruiting locally, they hope to fill gap in those districts and improve retention. And also, to eliminate the ‘volunteers’, the qualified people working without being on the payroll, because that process was so lengthy.” (8001, line 36 – MoHS).

Issues and challenges in the decision-making process

The decision-making process that led to the selection, design and implementation of these reforms was far less smooth than it would appear from the end results presented above. In this section, we present the main issues that emerged during the interviews with the key informants.

Sense of urgency in decision-making

Many respondents who participated in the design of the reforms felt that their preparation and launch was rushed. The time allotted for this process was limited and decisions had to be made quickly. There was not enough time to thoroughly analyse problems and discuss potential solutions. At times, this caused frustration among some of the actors.

“I mean, he [the President] announced that we were going to get free healthcare and then we had less than half a year to prepare. So you can understand that when we were looking at human resources in the light of free healthcare, we, I mean -- we had to make choices.” (9001, line 164 – NGO).

“After the free healthcare then everything appeared to come together, although I don’t think the free healthcare was properly prepared. It was good, but it was rushed” (9004, line 136 – MoHS).

“[...] everybody was in a hurry, I mean, including the President, because the President said that it [the FHCI] would have to be ready in April [...]” (9017, line 88 – donor).

Role of Technical Assistance

As the FHCI had such a high profile, both nationally and internationally, many actors participated in the preparation work. Many of the development partners involved sent Technical Assistants for specific tasks.

“A lot of technical assistance came in from various donors to help with specific things [...] Depending on what kind of topic, they would decide and find a person. And of course, I mean, it was sometimes a little bit wild, because things had to happen so fast. [...] At times, there were so many, there were so many TAs. You know, that means, when I was in meetings I sometimes would say, ‘I am so and so and I’ve been already so many years in country’, because otherwise people would think again I was a three-week TA.” (9001, line 270 – NGO).

The arrival of a large number of external consultants focusing on different issues, for different lengths of time, often in an uncoordinated manner, did not ensure coherence in the decision-making process. It also led to duplication of work and a loss of institutional memory. An example of this is the payroll cleaning system. While some of documents (Heywood, 2010 & Krisifoe, 2011) state that ‘ghost workers’ were identified and removed from the payroll, other actors recall that a national cleaning of the civil servants’ payroll had already been carried out a few years earlier. The second, health-specific cleaning was to remove the HWs who had to be subsequently re-entered into the payroll. This process appears to have caused much confusion and delays, at the time when action had to be taken swiftly.

“The reason why these people looked like ghost workers is because nobody in the Ministry of Health was keeping coherent records about where workers were posted, so because we had no records we didn’t know where people were supposed to be. So then if they weren’t where we thought they were, they would get recorded as ghost workers, whereas that was probably because the Chief Medical Officer had sent them somewhere else, or the Nursing Officer had sent them somewhere else.” (line 1050). “They stopped being paid overnight, and then it took months and months and months to reconstruct the health payroll. And this was happening at exactly the same time as the free healthcare implementation.” (line 926). “Why weren’t there any ghost workers? It was [because] a civil service-wide cleaning of the payroll [had been done] about 2 years earlier!” (9018, line 1095 – TA).

“We [MoHS] did a survey to establish the requirements for all cadres at each level, leading to a staff list in 2004” (8003, line 16 – MoHS).

Conflicting donors’ agendas

It emerged that there was some disagreement between donors on the design of the HRH policies to accompany the FHCI. In particular, these disagreements focused on merits of a salary increase compared to the introduction of a performance-based financing (PBF) scheme.

“These meetings [of the HRH Working Group] were completely dominated by [two donors] having their ideological fight effectively. I mean, it wasn’t just those two individuals but these meetings achieved very little, because, when these two big donors are busy having a fight, week after week after week not much else gets discussed” (9018, line 766 – TA).

Although it was recognized that PBF would improve the accountability of HWs, it was also agreed that setting up a PBF scheme would have higher transaction costs and take longer than implementing a salary increase. This was perceived as a major disadvantage in the rush to launch the FHCI. As one respondent recalls decisions were ultimately made on the basis of feasibility.

“PBF would provide an increase of revenues, but at the same time it would create an incentive to ensure people are present and they are providing some adequate quality [of services]. I remember that DfID was quite opposed to that [PBF], with two reasons; I think the official reason was that basically setting up the PBF mechanism would delay the implementation of free care, which is true. That was a good reason. It takes some time to do that. But I think the unofficial reason was also that they just didn’t believe in PBF. I heard some very strange points [...], DfID was saying that we should increase the salary [as this would] basically create amongst health workers a moral duty to serve the patient [...]. So ultimately I think that, well, given that PBF was taking more time and that everybody was in a hurry, [the salary increase was adopted].” (9017, line 78 – donor).

However, some of the respondents highlighted that the discussions between donors on this issue often ignored the perspective of the MoHS.

“I think that the Ministry of Health was more in favour of PBF, because I would say their concern was really on the accountability of health workers.” (9017, line 66 – donor).

“Interestingly people tell you it is the government to decide. That’s what they say, government has to decide. So I did an options appraisal [...]. I did a comprehensive thing when I went to present. As I presented [...], I remember a furious lady who got up and said ‘no, no, no, no, we will not accept that. It’s not the one’, and I said, ‘well, you said government is to decide’ (laughs). Well, she got up in the meeting and said ‘no, no’.” (9009, line 932 – MoHS).

The MoHS appeared to be caught in the crossfire between donors, and the pressure of the funding possibilities which came with one or the other’s support. This could also be due to contrasting perspectives internally, within the MoHS.

Adding to these discussions, in March 2010, just a few weeks before the FHCI launch, HWs organised a nationwide strike. The main issue being negotiated between HWs and the MoHS was salary, given the envisaged increase in the workload from the FHCI. At this point in time, the salary increase became inevitable. A wider public service pay reform was also considered by the government, but financial constraints meant that it was impossible to implement. The salary increase was therefore limited to technical health workers, even though there were still questions around how it was going to be funded. A salary increase for HWs was approved and the PBF proposal remained an idea that could be developed later on (see section 3.4.2).

These challenges described in the decision-making process led to a fragmentation of policies and strategies. Moreover, the actors involved tended to focus on the immediate design of the policies and there was little attention given to their implementation, which appeared to be even more fragmented and ineffective.

Financing of HRH-related reforms introduced for the FHCI

While most of the HRH-related reforms introduced in preparation for the FHCI (payroll cleaning, Sanctions Framework, etc.) required donor-supported technical assistance, the major funding requirements were for the salary increase.

Most of the informants recognise the role that DfID played to fund the costs of the salary increase. DfID advocated for the FHCI, as well as in funding it providing the majority of technical assistance. In particular, they supported the increase in HW salaries and the purchase of essential drugs. DfID also came with clear ideas as to what accompanying policies should be implemented and requested measures that would “protect their investment”.

However, the interviews suggest that the Global Fund played an even more critical role. Although they were not regularly present in the discussions in Freetown, were not providing technical assistance and were less involved in policy design, the Global Fund provided much funding for the salary increase through its health system strengthening (HSS) grant. It also appears that this happened in an almost serendipitous way.

“[During the strike], the Minister of Finance thought, ‘ok if they [DfID] are paying, we will go for it’ [for the salary increase], he was under so much pressure by then. But they [DfID] didn’t! They paid a part of the incremental cost, and in the end it was this Global Fund Health System Strengthening project that actually saved the day and funded [the salary increase], because there was no fiscal space. [...] This [the availability of the GF HSS grant] is what made it [the salary increase] implementable. It wouldn’t have been otherwise [...]. So it then came in through the salaries rather than as top-ups.” (9018, line 478 -- TA).

“It [the GF HSS grant] was there and it’s definitely not related with free healthcare, it’s not related.” (9018, line 423 -- TA).

“The Global Fund money was just about right to cover the gap. It was... it was kind of miraculous in a way. It was... not miraculous, but [...] as far as I can tell, it was entirely coincidental! It was this application they [DPI] had made to Global Fund. They didn’t expect to get it and it happened to be that it basically covered the gap. And, and that’s what saved DfID’s back.” (9018, line 569 -- TA).

This confirms that there was a certain lack of coordination between the main actors involved. Despite aligning on the FHCI, the planning and financing of the reforms remained to be influenced by specific donors’ agendas.

1.4 HRH policies and measures: 2010-2012

After launch of the FHCI was followed, other policies and reforms followed. The timeline in the document review (Bertone et al., 2013) provides a graphical depiction of the timing of the reforms. It is interesting to note that during the interviews, reference was mostly made to two of these reforms: the PBF scheme and the Remote Area Allowance. Other strategies presented in the document review were mentioned less or not at all.

1.1.1. Performance-based financing

Introducing a PBF scheme had been discussed during the preparation of the FHCI. However, this option was sidelined in favour of a general increase in salary for the technical staff of the MoHS. This did not mean the complete abandonment of the idea and from the interviews, it seems that both the MoHS and development partners were still interested in the plan. The DPI and the World Bank continued to discuss PBF and the scheme was implemented one year after the FHCI.

Policy objectives and approaches

The set-up of the PBF scheme is better described elsewhere (GoSL, 2011). One important feature was that 40% of the PBF bonus had to remain at the healthcare facility for small investments and improvements, as well as purchasing of drugs and equipment. The remaining 60% is a performance bonus that is divided among the staff of the facility.

When asked about the rationale behind the introduction of PBF, interviewees provided different explanations. Some link the introduction of the PBF scheme to HRH issues, complementing HWs' salaries and providing a lasting incentive to improve performance.

"The thing about salary is that it is a contract. A salary rise will only motivate you for the one month. The next month you don't get motivated any more, it becomes regular, it's a contract. [...] So you know you need something more for motivation, you need something extra for motivation that I get because I work and it gets taken away from me because I don't work, that is what motivation, that is to me, that is what I think is motivation [...]. So this was why I supported the two-tier approach that is, number one, raise the salary of everybody, and then number two, give a performance based [bonus] that you get because you work or you don't get because you don't work." (9009, line 654 -- MoHS).

According to some, PBF allows focus to be given to the quality of the HWs performance, while the salary increase was geared towards increasing the quantity of the HWs.

"The second strategy we used during the designing was, [...] we have now increased salaries for our health workers. What that means, we are looking at the quantity of service people and delivery, but in terms of quality, can we look at the quality aspect of it? We increase the number of personnel, we increase their salaries. They are happy and they will be ready to provide services, ok. Fine. So let's look at the quality aspect of this. So when we look at the quality aspect of it during the design we talked about the performance-based financing as another strategy to complement implementation of the free healthcare so that's the way the PBF came on board, you see". (9010, line 91 -- MoHS)

The same respondent later provided a slightly different view of PBF, less related to the HRH aspect and more to the financing at facility level.

"What we did was, before we launched the free healthcare, we brought in the idea of upgrading the facilities. We agree that, 'ok let's start giving them what we call cash to facility, ok', and [...] we develop guidelines on how to use that cash to facility basically to upgrade their facilities [...]. Basic

things, like toiletries, curtains, you name them. [...] And then we used those cash for facility as a window of opportunity for PBF to enter". (9010, line 712 -- MoHS)

Drivers of change for the introduction of PBF

The analysis of the interviews showed no single issue as the main driver for the introduction of PBF. Many of the respondents noted that the introduction of PBF was led by the World Bank, who is also the main funder of the scheme. Other development partners were less engaged with this policy reform (if not openly opposed), although their position may have changed in more recent years.

"It was not agreed by everyone. We wanted to introduce PBF, we spoke with the district councils, we spoke with the PHU staff, we talk with them, we do the manual, we ask them are you agree and then we implement it; you don't need all of the partners to agree to PBF". (9009: line 900 – MoHS).

"Within and outside the Ministry. In fact some partners, like DfID, they never believed that a performance-based financing would be feasible in Sierra Leone. [...] But when we started they said, 'ah! Something is happening you know, you go to health centres you meet them they are clean in terms of hygiene, you check their records, they are ok you know. Check a lot of things, they are fine. [...] So some partners are coming on board now, they are coming on board because they have seen some of the gains that we are doing. [Interviewer: like, who for example?]. Like DfID. [...] They are now convinced that it's doable, you see and some of the partners also they are coming on board. Coming on board in a sense where you accept the idea. This is doable, this can work, this can provide what we want. Like, WHO is convinced that it is doable". (9009: 446 – MoHS).

It is clear that some people within the MoHS were in favour of the PBF scheme. It is interesting to note the division roles, between DPI and the Directorate for HRH (D-HRH). While the D-HRH is responsible for the salary increase, payroll clean, and Sanction Framework, via the newly created Payroll Office, the DPI was more directly involved in the design and planning of the PBF scheme and of the Remote Area Allowance (see section 3.4.2).

This division of roles was due to the mechanisms of donor's funding as well as operational and pragmatic constraints (the DPI is responsible for HIS data and was therefore chosen to verify the PBF data. It also employs the only health economist of the MoHS).

Interviewer: "Why do you think there is this division? Why do you think HRH is looking at the salary increase and DPI is looking at performance-based financing?"

Respondent: "Er, HRH is looking at the salaries because it's, well... it was thought that it's a human resource thing. They look at attendance registers and other things and they look at the cleaning of the payroll. It has been an HRH thing all along. But with the PBF and DPI it's simply because of the data verification. Well.. number one, because the data sits there, then number two, the [donor's] RCH funding doesn't target HRH Directorate. So HRH can only benefit if they decide to merge with DPI on the PBF".

Many of the respondents, especially those who collaborate with the D- HRH, have little insight into the design and working mechanisms of PBF. A lack of involvement from MoHS departments in this process resulted in further fragmentation in the design and implementation of the HRH policies and the incentives package for HWs.

Implementation of PBF scheme

The implementation of the PBF scheme began in April 2011, and it was run mainly by the DPI with support from the District Health Management Teams (DHMTs). The scheme was implemented

immediately at national-level, covering all the Primary Health Units (PHUs) in the country. Many of the respondents recognised that the PBF scheme faced some challenges, especially at the beginning.

The main problems were:

- (i) ensuring the understanding and acceptance of a new concept (i.e., performance-based) for providing funds to the facilities and the staff. Acceptance was particularly difficult where stakeholders that did not have much to gain from the scheme, or if they thought their power would diminish as a result of the scheme. For example, the DHTMs and their heads, the District Medical Officers (DMOs) were initially opposed to PBF.
- (ii) ensuring the smooth running of the scheme and the set-up of all the necessary procedures, including bank accounts and the flow of funds;
- (iii) ensuring the correct reporting and record keeping of the services provided from the PHU staff.

“So then gradually people accepted it and it was a new concept, it was a new game altogether. People find it difficult, but when we went into the district, we did a lot of training there, they see the importance of the PBF [...].” (9010, line 201 – MoHS).

“One of the biggest bottlenecks is ... some DMOs, the District Medical Officers, find it difficult to accept, the concept. The idea behind that was that the facilities can manage money on their own. [...] I mean in the country, we are now in the decentralization system. So let’s start pushing the responsibility to people. So, medical officers should have less to do in terms of management. You give [money to] the PHUs, the facilities.” (9010, line 701 – MoHS).

“The other [challenge] is dealing with bank-to-bank transfer, because [the PHUs] have the account in different banks [...]. So whenever the Ministry of Finance send authorisation to the Commercial Bank to effect payment, now when you have 1200 facilities across the country, the period of transfer took a lot of time. So that was another big challenge. The Ministry of Finance is working on that to see how best we can speed up things. There are still some delays, but the delay in terms of timing has reduced drastically. [...] And the other challenge is the reporting, timing reporting, timely reporting was another big challenge. Even though we still have it as a challenge, but not that much compared to when we started initially. [...] Data entry into the records was another challenge and some were finding it very difficult.” (9010, line 795 – MoHS).

These challenges caused extremely long delays in the payment of PBF bonuses to the facilities. The MoHS at central level thought issued were being properly addressed (*“There are still some delays, but the delay in terms of timing has reduced drastically”*), actors closer to the field reported that problems still remain. They also complained about the lack of communication and transparency between the central level and the districts surrounding the bottlenecks in the implementation process.

“They [the PHUs] have not received the last two quarters [of PBF payments]. [...] But they need money. A lot of them have agreed to give their PBF [to staff not on payroll], but with the PBF not coming, [...] then it’s like, ‘oh well, it’s not working’.” (9014, line 561 – NGO).

“If the PBF wasn’t going to come and that was communicated to people, donors and obviously the district health management team, that’s one thing. But it’s like people are just kind of waiting, they don’t know what’s going on, like the DMO in [name of district] is like, ‘I don’t know what’s going on’, and all of his staff are asking him ‘where is our PBF?’” (9015, line 189 – NGO).

Such delays in payment are perceived as an important problem. If HWs do not see the direct linkage between performance and payment, their performance may be disrupted. It could also jeopardise the future of the PBF scheme as a whole.

1.1.2. Remote allowance

Many of the respondents recall that a remote allowance for the HWs in rural locations was initially discussed during the preparation for the FHCI. However, although many recognise that this was an essential issue to tackle, the remote allowance was not introduced until 2012.

Different reasons emerge from the interviews to explain this delay. It is certainly attributable to the urgency in which the launch of the FHCI was being prepared. Also, there were no extra funds available to cover the remote allowance. Moreover, without the payroll clean and the rationalisation of the HWs database, it was impossible to know which HWs were entitled to a remote allowance.

“For the remote allowance, the design was done even before the free healthcare started, but the problem was, who is going to fund this? [...] I think, we made three or four different designs even before free healthcare started, but then the question was who is going to pay for this and which design is going to be picked? And what work? Because the thing is if you are going to pay remote allowance, you need to know that that person is really remote. But we didn’t have that information. Then the Global Fund came in and Global Fund money was used to help the salary increase, but then I believe in the end they also helped with remote allowance”. (9001, line 560 – NGO).

The remote allowance is granted to the HWs based on a ‘remoteness’ score calculation based on the distance of their facility of posting from the district headquarter town. The HWs then receive an amount in their bank account, separate from their salary³. The allowance is funded by the Global Fund, however many agree that it is not well implemented and that it rarely reaches the HWs that are eligible for it. There appears to be a lack of continuity in Global Fund funding, which may be a reason for these problems, however none of the informants were familiar with the mechanisms for eligibility and funding of this allowance, so this topic remains unclear.

The lack of awareness about the design and implementation, and sometimes even the existence of the allowance, is a surprising element emerging from the interviews. Many of the respondents, including some working exclusively on HRH issues, had to be explicitly asked about this policy and would not recall it when listing the HRH policies in place. Others, such as representatives of NGOs working in the districts, were not at all aware of the existence of this allowance.

“I’m actually not familiar with the [remote area allowance]”. (9014, line 534 – NGO).

“It’s also really interesting that [name of person] who is our national health co-ordinator [...] does not know about it. And what’s interesting is that I heard many, many health workers, PHU staff, and DMOs talk about performance-based financing. I’ve never heard anyone mention this remote area allowance”. (9015, line 556 – NGO).

There is once again a strict division of tasks within the MoHS, in particular between the DPI and the Directorate for HRH, with regards to designing and implementing the remote allowance. Because the DPI cannot pay the allowance without information from the D-HRH, the D-HRH provides a staff list to the DPI who then does the calculations without providing any feedback to the D-HRH/Payroll Unit on which payments have been processed. It is not clear whether the funds are disbursed directly by the National AIDS Secretariat (the principal recipient for the GF HSS grant), the MoHS, or the Ministry of Finance.

³ However, it is not clear whether this amount is fixed or calculated as a proportion of the HW’s salary. None of the respondents was able to provide further details on this and no document on the working mechanisms of the remote allowance was retrieved.

The remote allowance appears to be another instance of fragmentation in the design and implementation of the HRH policies. It created a 'vertical organization' of the policies within the MoHS, as if they were different programs although they all had the overarching goal of improving conditions for HWs.

1.5 Remaining HRH challenges

Despite the problems highlighted thus far, there is no doubt that important progress has been made in advancing HRH policies in Sierra Leone. However, many of the respondents agree that reforms are partial and not all the HRH challenges have yet been resolved. This section focuses on the remaining challenges that emerged from analysis of the interviews: the recruitment and deployment of HWs, their training and the non-financial incentives environment.

Recruitment and deployment of Health Workers

To increase the number of HWs in preparation for the FHCI, and ensure they were distributed equitably across the country, HWs were recruited locally through a mobile recruitment programme. However, this remained a one-off exercise.

At the same time, the establishment of a Health Service Commission (HSC) was planned to facilitate the routine recruitment of HWs. The HSC was supposed to replace the Public Service Commission (PSC) and Human Resources Management Office (HRMO) and deal with recruitment, deployment, career progression, leave, retirement, etc. The idea was that the HSC, would have a specific focus on workers in the health sector, rather than in the entire civil service, and will deal with recruitment and deployment more effectively. Despite the HSC being established by a Governmental Act in 2011 and the Commissioners being already nominated, the HSC appeared to be non-functional at the time of interview (March 2013).

"Yes, there were going to be a Health Service Commission. Ok, I have seen their new office on the outside, but I am not really sure they are really functional at the moment". (9001, line 224 – NGO).

One of the respondents points out at how this is an example of the unfinished process in carrying out the necessary reforms to address the most pressing HRH challenges and issues.

"But reforms are still partial. For example, the HSC has been set up but there is no consensus what it will do." (8002, line 40 – donor).

Another issue discussed was the centralisation of the recruitment process. Beyond the one-off mobile recruitment programme, HRH recruitment and deployment remained a highly centralized procedure, despite the ongoing devolution process that should see some of these functions devolved to DHMTs or Councils.

"Recruitment was very centralised and slow: after training, people filled in PSC forms. The MoHS endorsed them and they were sent to the HRMO for appointment. However, appointments depended on vacancies and budgets and often took time. Individuals were posted, rather than having any choice in where they went." (8001, line 19 – MoHS).

"In terms of recruitment, the bottleneck there is [that] recruitment was centralised. And now with the devolution, the district councils are supposed to also be involved in recruitment, but as far as I know recruitment is still it's centrally placed. [...] That's another serious issue in terms of the Human Resource at district and central level: the communication between central level the district level. Sometimes the District Medical Officers, they just see a group of health workers being sent to them with a list that

these are the ones that are coming to work [...]. The postings committee is seated here [in Freetown]". (9007, line 680 – donor).

The centralization of the HRH management means district level staff are unable to see the geographical distribution of HWs to their districts or make decisions on HW deployment.

"I believe we have a Postings Committee in Freetown, that is in the Ministry of Health. I believe this posting committee consists of several expats who sit there and work on the staffing situation together with Human Resource Management and then they will make their decisions etc. [Interviewer: are you a member of that postings committee?]. I wish I were but I am not". (7001, line 70 – MoHS district level).

"I am not directly involved in staff and recruitment. I only get staff that is posted to me. I am not even a part of the recruitment team. [...] Hmm (laughs). It is strange, it is a strange process, [...] you don't hire and you cannot fire. So that has many implications from staff discipline, staff commitment you know. [...] They do the postings from head office, from Ministry of Health and they don't even seek your opinion. That too is not right, especially if you have a worker that is helpful, and then that worker is suddenly withdrawn and sent elsewhere and then someone that is not as competent as that person is brought in to take his or her place. You find such situations quite difficult to cope with". (7002, line 32 – MoHS district level).

Training of Health Workers

The training of HWs and the introduction of policies improve pre-service and in-service training of HRH emerged as one of the weakest areas of reform in the document review (Bertone et al., 2013). This is confirmed by the key informant interviews. Indeed, it seems that training, and in particular pre-service training, has been overlooked to focus on the issues that are most compelling, but which also demand less time to be addressed. Many respondents agreed that rush to launch of the FHCI which shifted the focus towards the quantity of HWs available, rather than providing training to improve their quality.

"Because of the free healthcare initiative, the focus was more on trying to get people to get access to health, the focus was on that. Now the tide is changing, because the focus is now on quality services, on the delivery of quality health service. And so again training becomes more permanent, so the climate is right to address these issues". (9006, line 90 – MoHS).

In recent years, more attention has been given to training a HRH Training Policy and Plan is currently being developed. This is envisaged to focus initially on higher levels of training, specifically post-graduate training.

It is interesting to note that only one respondent explained how, before the FHCI period, nursing schools were set up in each of the districts. This was an important step to ensure the pre-service training of lower cadres of HWs.

"They shifted training schools out of Freetown, accrediting nursing schools up-country. This happened around 2005-6. There are now training schools in every district". (8003, line 31 – MoHS).

Non-financial incentives

Although much attention has been given to providing financial incentives to motivate and retain HWs (including salary increase, PBF bonus, remote allowance), respondents felt non-financial incentives have been overlooked. It is important to note that it is mainly NGOs and respondents at district level, i.e. those who work more closely to HWs, who raised this issue.

One NGO conducted a survey into non-financial incentives for HWs. They found that HWs are generally demotivated, unsatisfied with their own quality of work, and that ‘relationships’ are key to influencing performance and job satisfaction.

“So you can see from these statistics that [the HWs] are not feeling very good about their jobs. Most of them are just really unsatisfied, which does not come as a surprise. [...] This is about recognition and respect. They [the HWs] are not feeling respected by their supervisors, they are not feeling respected by their communities, so you are getting a picture that they are pretty unhappy. But what’s really interesting is that they also have really negative assessments of their own performance. So when asked, can they provide high quality of care?, almost all of them are saying ‘no’ or ‘rarely’. Can they use their abilities and skills to do their job well? ‘No’ or ‘rarely’. Are they punctual? they say, ‘rarely’. These are all the common things that people say about health worker, that they don’t come on time or they don’t give me a good quality of care. But health workers themselves are feeling very negatively about what they are doing” (9015, line 49 – NGO).

The NGO is now implementing two projects; one to facilitate peer-to-peer support of HWs and another to provide counselling and training to HWs to help them cope with any problems in their professional life. The impact of these projects is still being evaluated. A third project, which involved organising a competition among PHU staff, has also been implemented in some chiefdoms. Initial results show that the provision of a non-financial award to the successful PHUs contributed to the staff feeling supported and valued for their work. These projects remain at pilot program-scale and it is not clear whether they will be included under the official policies of the MoHS.

Respondents also pointed out the poor conditions of service, such as transport, housing and other benefits for HWs and their families, especially for those working in remote areas. Many suggested these factors cannot be simply replaced by a remote allowance to complement the salary, but need to be addressed in a more comprehensive way.

“I mean, the remote allowance is a nice idea but it will not solve everything. Why does someone not want to work in a remote rural area? There are many reasons. It’s not accessible, you have a problem with transport, but also there is no staff quarter, yeah. A lot of those places there is no proper place, there is no school for your children, there are no shops, ...” (9001, line 526 – NGO).

Finally, another area that has been insufficiently addressed is that of career progression.

“I believe we need to be fair and transparent. Tell them opportunities that are available, future developments programmes, etc. Because, you see, if somebody is sitting at one level for ages and is not growing professionally, they stay put, they give up and they become disgruntled with everything themselves inclusive” (7001, line 742 – MoHS district level).

“Good salaries should form a part of the package but that is not the whole answer. A salary which is in line with your competences, yes, but that is not all that the worker needs to be happy and to be satisfied and that is not all you need to retain a worker. They should have a career path to advance themselves to increase their knowledge, to be promoted and so on” (7002, line 378 – MoHS district level).

These remaining HRH challenges emerged clearly from the interviews and demonstrate how these reforms remain incomplete. Moreover, these examples show that the rushed launch of the FHCI did not allow time for issues that would require more time to be addressed. Additionally, after the launch of the FHCI, the momentum for reforms was reduced. Some policies affecting HWs were introduced (e.g. PBF and remote allowance), but they were not effective in their implementation. The adoption and implementation of other measures to address the remaining issues (such as those presented in this section) slowed down or entirely stalled.

1.6 Other themes related to the ‘post-conflict’ context

It is interesting to note that most of the respondents did not refer specifically to the post-conflict context, despite being told before the start of the interview that the focus of this research was HRH during this period.

Since this theme rarely emerged from the discussion, the researcher mentioned it openly towards the end of the interviews to solicit the views of the informants on this topic. Most respondents recognised that Sierra Leone suffered a long and devastating conflict, but as the conflict ended 10 years ago, they did not seem comfortable with the term ‘post-conflict’ or rejected it altogether. Some asked for a definition of ‘post-conflict’ and wondered if it applies to Sierra Leone now. In general, they did not consider their country to be in a post-conflict phase anymore.

“Sierra Leone has moved beyond that [post-conflict phase] now. There is not much link. We can’t use that as an excuse”. (8001, line 128 – MoHS).

“I don’t think we are post-conflict anymore. I mean, I know there are other definitions, yeah, but according to my feeling, I wouldn’t call the country ‘post-conflict’, [...] and also I don’t like it because it brings us back in the past”. (9001, line 875 – NGO).

In particular, linking policy-making processes to the post-conflict context seemed a difficult and somewhat obscure exercise for most of them. The researchers were left with the task of unravelling possible patterns and themes with reference to the ‘post-conflict’ context. This was achieved with assistance from the relevant literature (Witter, 2012).

Inadequate management capacity and skills

In the literature capacity, or rather the lack of capacity, at all levels in the health system has been shown to hamper progress in the post-conflict reconstruction phase and limit the stewardship of the government (Witter, 2012). Surprisingly few respondents mentioned this issue explicitly during the interviews. Only one mentioned a lack of expertise and capacity as a possible cause for the slowness of the reform process.

“It [HRH reforms] started later because [...] there was no expertise in the country, people who could think strategically, [...], you see that was not available. You know, those are all challenges to any given government when you are operating in a post-conflict country, you need people with the expertise who can come and sit and think strategically how to put things in place”. (9010, line 943 – MoHS).

Referring to the period around the launch of the FHCI in 2009, another respondent from an international organisation outlined how some of the officers at the MoHS had the skills needed to drive the reforms. However, the limited number of capable staff rather than their skillset, represented the key capacity problem.

“This level of understanding is something I have not seen in other countries. Most of the countries they usually forget or neglect something, but in this case in Sierra Leone they were really thinking right about what would happen, what should be done even if they were not able to do everything but at least, I mean, they had some very clear understanding of the consequences [of introducing free health care]” (9017, line 52 – donor).

“It’s really appalling, the low capacity they have. They have just two or three persons in the directorate that are able to think about some policies or that are able to write a report”. (9017, line 276 – donor).

Contracting-out of service delivery

A number of post-conflict countries, such as Cambodia, Haiti, Afghanistan, Southern Sudan and Liberia, have contracted-out health service delivery to external actors (usually international NGOs) (Witter, 2012). In Sierra Leone however, services have continuously been provided by the MoHS. This theme emerged a few times in the discussion, especially when comparing with neighbouring Liberia.

Views differed on the merits of contracting-out services and why this approach was not adopted in Sierra Leone. Some suggested contracting-out would have required closer collaboration with external actors, which could have reinforced the capacity of the government and the accountability of the MoHS staff e.g. by limiting for the number of political appointees within the MoHS.

Others suggest that the reasons for not contracting-out services are related to the specific context in Sierra Leone. After the conflict, governmental authority was (more or less) extended to the entire country, which contrasted with other post-conflict countries such as Afghanistan. Secondly, the health system and the leadership capacity of the government did not appear to be as disrupted as in other contexts.

There was a delay between the immediate post-conflict period and the first wave of 'formal' reforms. While in the initial post-conflict, external actors focused on and financially supported 'fire-fighting' measures. They were not working in collaboration so that major reforms could not be introduced. By the time of the FHCI, the capacity of the government and basic health system infrastructure was already advanced enough to not require services to be contracted-out to external agencies. Also, the influence of development partners and their preferences on health systems reorganisation may also have played a role.

The choice of not adopting a contracting out approach in the early recovery years in the immediate aftermath of the conflict had lasting consequences which affected the future development of the healthcare system, so that service delivery is directly implemented by the MoHS through public health facilities. In this sense, it is interesting to note that, while contracting-out was not adopted as a strategy for the healthcare system, PBF, which often includes some contracting mechanisms, was introduced in 2011. In Sierra Leone however, PBF is strongly rooted in public service delivery and contracts are set-up, verified and executed internally within the MoHS.

Decentralisation

Another theme highlighted in the literature as common to some post-conflict contexts is decentralisation. A similar pattern can be seen, whereby initially after conflict, the government recentralises decision-making and policy implementation to restore its power and legitimacy which may have been lost during the conflict period. Conflict can often determine a *de facto* decentralization of the system as the central government loses control over certain areas and cannot ensure its presence. The recentralisation of the political and administrative system in the post-conflict period often clashes with the need to support the decentralization or devolution of power towards lower level of government (WHO, 2005).

In Sierra Leone, the interviews seem to confirm a similar pattern. The government and the MoHS tended to maintain control over policy-making processes and policy implementation. However, because of the distance from the field, implementation was less effective. This would improve if this process was decentralized to district-level e.g. to the Council or to the DHMTs as envisaged by the Local Government Act of 1994 (GoSL, 2004). This was highlighted by those actors that work closely at local level.

“We have a system for dissemination. It’s just that, it doesn’t always get to everyone in time. And I think the other key thing is that, I imagine most of us have been to some sort of policy or strategy launch, what I’m not clear on is how what is getting launched down to the district levels, and the actual acceptance, uptake of that policy and strategy. None of them [at district level] actually ever seem to get embedded into...” (9014, line 428 – NGO).

“The real key issue is that with all of these policies and all of these strategies, none of them have been properly operationalised and none of them have stayed around. Like, in 2002, there was a free health care policy announced for pregnant women, lactating mothers, under 5, the elderly, disabled, all this, right, and then it just didn’t happen. So free health care is announced again in 2010, and it’s like, OK, it’s happening, but is that going to slowly start to fall apart? If PBF is announced, it’s like, oh it’s comes and then it stops, you know.” (9014, line 801 – NGO).

The tension between the wishes of the central MoHS to maintain control and the contrasting pressures for decentralization creates yet another layer of fragmentation between policy-making and planning at central level and actual implementation at local level.

4. Lessons and conclusions

How policies developed

The analysis of the key informant interviews seems to confirm the same main phases in HRH policy-making in Sierra Leone that were highlighted in the document review. It also enriches the narrative portraying a process that is less linear from what it appeared from the documents alone. In this section, we will describe the stages of policy development and any challenges faced.

The initial post-conflict period was critical to the reconstruction of the health. It was the decision *not* taken at this time to contract-out health services that defined a healthcare system where the MoHS is in charge of service delivery. However, the measures taken to address HRH issues were rarely translated into formal policies of the MoHS and instead issues were tackled using a ‘fire-fighting’ approach. Development partners preferred a fragmented approach, often implemented without the involvement of the MoHS e.g. by hiring HWs directly.

By the end of 2009, the combination between the national political conjuncture with the new government interested in implementing a visible and successful flagship reform, the international momentum around the reform of health system financing and the introduction of fee exemption (and the major role played by some donors in this), as well as the urgent health needs of the population (Sierra Leone is one of the country with the highest maternal mortality in the world) led to the opening of a political window of opportunity for a strategic reform. In early 2010, the FHCI was launched. This reform was immediately perceived by all actors as both essential and complex. Failure to deliver the FHCI was politically unfeasible so a lot of pressure was put on the MoHS and its partners to design this reform effectively. The FHCI pushed HRH issues much higher on the political agenda, both within the MoHS as well as among donors.

This resulted in a wave of HRH-related reforms. The importance of the FHCI helped to increase coordination between different actors and align the efforts of the MoHS and partners. The approach adopted for decision-making seemed to be very pragmatic. Although evidence and health needs certainly played a role, given the short time frame available, not much time could be spent conducting baseline surveys and situation assessments. The issue of the availability of funding was also pressing, which could have allowed some space for donors’ interferences in driving the decision-making process.

The series of reforms that accompanied the launch of the FHCI have been relatively successful in terms of addressing the most pressing HRH issues. These reforms contributed substantially to the rationalization and improvement of the incentive package available for the HWs.

It is interesting to note that most of the respondents, especially those working at central level, focused their narratives almost exclusively on the design and the planning phase of the reforms. Few of them discussed the implementation phase and the challenges it brought, or were aware of any evaluations of the impact of those reforms. This confirms that attention was given to the design of the policies and far less focus was given to the implementation and how policies were translated into practice. For example, there is also very little awareness at central level about the PBF and remote allowance schemes and both of these incentives currently face long payment delays. Additionally, few rigorous evaluations of the policies have been carried out thus far⁴.

Preferences were also given to one-off exercises, e.g. the mobile recruitment programme, or shorter-term, practical solutions, rather than an organic and coherent reform package e.g. the decision to overlook pre-service training or the postponement of the remote allowance.

“On the package for reward, incentives .. it was a bit lost, not looking at the international evidence. [...]. I don’t know how you would say that, but a kind of bricolage”. (9007, line 139 – donor).

Despite the noteworthy increase in the alignment of partners with ministerial policies during the preparation of the FHCI, there appeared to be some disconnect between the different actors. A lack of coordination became more problematic after the introduction of the FHCI, as the political pressure for rapid reforms was reduced, leaving room for fragmented policy-making. Disconnections appeared between MoHS and donors, among donors, and even between the different departments of the MoHS and at different levels of the administrative hierarchy (central and district-level). The result of this fragmentation is a set of policies that are not completely coherent and a largely ineffective implementation of these policies. This led to an incentive package for HWs that seems to be poorly understood at individual level and is therefore unlikely motivate them to improve their performance⁵.

After April 2010, a new phase in HRH policy-making can be identified. In this period HRH reforms slowed down and became patchier. In recent years, there appears to have been a loss in momentum for rapid reform, which has caused numerous issues to be addressed slowly or stall altogether. For instance, the working groups nearly stopped meeting altogether; therefore coordination has become more difficult. Without the political pressure for reform, implementation of the policies has not closely followed the design and this has led to delays in their execution.

The country’s conflict and post-conflict trajectory – its legacy and lessons for the future

While the analysis of the key informant interviews highlighted some interesting points and patterns, it is not easy to highlight which features of the policy-making process are specific to post-conflict. Our analysis seems to show that identifying themes and processes that can be undoubtedly defined as specific for post-conflict contexts is not an easy task.

A broader health financing reform as an entry point for HRH changes

⁴ Although a comprehensive assessment of the FHCI and the related reforms is ongoing.

⁵ Further, complementary work on the incentive environment at individual HW level is being carried out by ReBUILD Project 2 with the analysis of the Health Worker Incentive Survey (HWIS).

The pattern of HRH reform in Sierra Leone is not uncommon to other contexts, whether post-conflict or not. The most salient moment in this case was the introduction of a broader health financing reform, the FHCI. Although this reform was not specifically focused on HRH, it had a critical impact on HRH reform. As one of the respondents clearly points out, without the FHCI and the high political stakes that it involved, HRH issues would not have risen high on the agenda of either government or donors.

“That’s why I said this is a process and human resources is part of that process. It’s not a standalone [issue], it’s part of a process. And they were lucky that because of the free healthcare there was so much attention to human resources. Otherwise, I wouldn’t know where we would be now [in terms of HRH reforms]. Worse off, most likely”. (9001, line 864 – NGO).

Another informant suggested that having a broader healthcare financing reform helps to push new HRH policies and have them accepted.

“My point is that the entry point for improving Human Resources for health is health financing. I think it’s a lesson for policymakers. All the countries that I have seen where they push up front the issue of HRH, that just doesn’t work because usually the Ministry of Finance says, ‘oh no, that’s too expensive; that’s complicated’. The donors they basically feel the same. But when you see things exactly the other way around, I mean where you start with a health financing reforms then that’s much easier to implement something for HRH. [...] My point is simply if you do your advocacy only on HRH most of the time it fails”. (9017, line 352 – donor).

The creation of a broader health financing reform to open a political ‘window of opportunity’ for reform in the health sector is not unique to Sierra Leone. Although the literature often refers to a ‘post-conflict window of opportunity’ during which there is often substantial donor support available (WHO, 2005), it is difficult to claim that the opportunity for reform was exclusively linked to the post-conflict situation in Sierra Leone. The FHCI was also launched 8 years after the end of the conflict. Rather, it seemed to be connected to external political factors, both nationally (the new government formed in 2007 and the need for a successful, flagship program in health) and internationally (the donors’ support for the introduction of free healthcare, rather than during the immediate post-conflict).

However, it could be argued that some elements that are typical of a post-conflict context facilitated this process and that the launch of the FHCI reform had even broader consequences on the restructuring of the health systems because of the post-conflict setting. In the document review, we identified the fluidity of power dynamics between influential actors as one of the possible post-conflict characteristics that would facilitate reform. An example of this emerged from the key informant interviews. While in other countries professional bodies are a powerful actor and the relations between these bodies and the MoH are entrenched in the system, often limiting the space for reform on HRH issues, in Sierra Leone the power relations with the professional associations seems much more fluid. It emerged from one of the interviews, that the Nursing Board, is chaired by the Director of the Nursing Department in the MoHS. As a consequence, the board is by definition aligned to the decisions taken by the MoHS and quite weak in its contracting powers, therefore minimising opposition to radical changes. For example, the introduction of the Sanction Framework and the PBF scheme came were unopposed by any of the professional bodies.

It is possible that, since the health service was lacking a strategic vision and reforms had stalled for a few years after the end of the conflict, the introduction of a new policy had far-reaching consequences. Given the post-conflict context, the launch of the FHCI could not be based on some relatively minor, incremental measures, but needed wider changes as there was little to build on.

The 'narrative of success'

In the section, we have highlighted some of the downsides of having HRH changes closely linked to a broader health financing reform, rather than a coherent and organic reform process. The FHCI was undoubtedly critical to addressing HRH issues and, despite a lack of formal evaluations, the package of reforms introduced have been mostly successful. This is confirmed in the interviews, particularly by the respondents at central level, from whom a sort of 'narrative of success' emerges.

While this narrative may be partially true (progress on policy-making in the years around 2009 and 2010 was substantial, especially if compared to the stalemate of the previous period), it could be instrumental to sign the distance from the conflict and the immediate post-conflict period. It is also counterbalanced by the analysis of the challenges that remain still to be addressed, perceived especially by actors at that level. Beyond this 'narrative of success' depicted at central level, the consequences of the reforms and their implementation at peripheral level, as well as the success in reforming the incentive environment for HWs and improving their performance at individual level, need to be analysed further.

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