The development of HRH policy in Sierra Leone, 2002-2012 – a document review

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Executive Summary

Introduction and objectives

This document presents the findings of the document review, which is one of the components of ReBUILD Project 2 focusing on Human Resources for Health (HRH). The objective of this review is to describe the HRH context in Sierra Leone and the HRH policies that have been introduced during the post-conflict period. We aim to understand the reasons for their introduction, how they have been implemented, and what effects any policy changes have had. The document review serves both to guide future work of the ReBUILD team in Sierra Leone. In addition, it will provide clues on how and why certain HRH policies were developed and implemented in the post-conflict environment as well as evaluating their effects on the country's HRH and health policy objectives.

Methods

A document search identified 76 documents (**Annex 1**). After an initial screening, 57 were reviewed as these were deemed relevant to HRH issues in Sierra Leone (**bold** in Annex 1). 21 documents (28%) are official policies and strategies of the Ministry of Health and Sanitation (MoHS) and the Government of Sierra Leone (GoSL), while 17 (22%) are informal documents of the MoHS. 12 documents (16%) are evaluations and technical assistance reports, while 14 (18%) are independent studies, briefs and research articles. Only 1 document is authored by a donor. The remainder are statistical reports (7 – 9%) and civil society or media publications (4 – 5%). Documents were analysed using thematic analysis. A series of 'themes' were identified by the team and the documents were code according to these themes.

Findings

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

Availability and retention challenges: Documents from the MoHS show the sharp loss of qualified health workers (HW) from in Sierra Leone suffered during the conflict and the gap that remained in the aftermath. The main causes of attrition were death, migration or HWs joining the non-governmental organisation (NGO) sector. In 2011, the HRH situation remains dire. The *HRH Country Profile* highlighted very high vacancy rates for health professionals in the MoHS.

Distribution challenges: No information is available on the geographical distribution of HWs before 2010-2011. Recent data reveal that the deployment of HWs is highly skewed to urban areas.

HRH production challenges: The GoSL, through the Ministry of Education, Science and Technology and the MoHS, owns 7 of the 12 existing pre-service training schools. The highest concentration of these schools is in the Western Area (5) and issues have been found with the training curriculum. It also emerged that Ministry of Education, Science and Technology institutions and private institutions do not discuss training targets for all disciplines of health staff with the MoHS and sets its own targets on the basis of its internal capacity.

Recruitment and deployment challenges: Recruitment of HWs is done centrally by the Human Resource Management Office (HRMO) and the Service Commission (PSC) of the MoHS. The process is very bureaucratic and recruitment and deployment can take 3-6 months to complete. Changes to this recruitment process are envisaged for 2012 with the creation of the Health Service Commission, described below.

Performance challenges: Prior to the conflict, HWs' salaries were often paid irregularly and were appallingly low. In the immediate post-conflict period, NGOs and other humanitarian organizations not only provided emergency health services, but also gave financial incentives to some HWs. When these organisations left, the government was not able to maintain the same incentive environment. Following the introduction of the Free Health Care Initiative (FHCI) in April 2010, a series of HRH

changes were implemented which included a several-fold increase of HWs salaries, the introduction of a Staff Sanction Framework, and the implementation of a Performance-Based Incentive Scheme in Primary Healthcare Units (PHUs).

HRH governance challenges: Until 2011, the MoHS had a Unit for Human Resource which was in charge of dealing with all issues relating to HRH, and in 2011, this was upgraded to a Directorate. While there is an ongoing decentralisation process, at district level there is no HRH unit and the personnel administration is left to the general clerks.

Official HRH policies responses, 2002-2012

Policy objectives and approaches: In 2004, the first *Human Resources for Health Development Plan* was written and recommended the development of a HRH policy, which was completed in 2006. The *HRH Policy* (2006) was a relatively vague normative framework rather than an operational document. It explicitly allowed flexibility in the activities proposed "given the current level of uncertainty regarding the exact nature of the reforms and the detailed staffing requirements to support the National Health Policy". The subsequent national health policy, the *Sierra Leone National Health Sector Strategic Plan 2010-2015* (NHSSP), addressed HRH issues, identified the main HRH challenges, and embedded a strategic plan with objectives, actions and targets. However, the objectives and 'targets' remained mostly programmatic, recommending the development of new plans and policies. As envisaged by the NHSSP, the new *Human Resource for Health Policy* and *Human Resource for Health Strategic Plan 2012-2016* were developed in 2012. These documents are heavily influenced by the changes that have taken place since 2009 in relation to the introduction of the FHCI. The 2012 policy mostly acknowledges the already implemented HRH changes.

Drivers of change: the analysis of official policies and how they evolved over time shows how official documents continue to highlight similar challenges and describe similar solutions, whilst rarely proposing actual implementation plans. This demonstrates the variability of the context in the immediate post-conflict period (2002-2009). In the case of the 2012 documents, which follow the launch of FHCI in 2009-2010, one could argue that they were prepared to give *ex-post* an official shape to the reforms and changes that had already taken place.

Implementation of policies: Little was done in terms of implementation of policies prior to 2009. The situation has since changed, with the approval of the NHSSP and the launch of the FHCI, coupled with the related HRH reforms that are further analysed in the next section.

Financing of policies: Similarly, little or nothing was done to guarantee the funding of the propositions advanced in the HRH documents before 2009. After 2009-2010, as the implementation of reforms became more coherent, budgeted plans and expenditure frameworks began to appear. However, they focused more on the funding of the planning activities (e.g., preparation of policy documents), rather than on the actual implementation costs.

Impacts: Given that most of the HRH policies have either been partially or not implemented at all, it is unsurprising that there is an absence of impact evaluations.

HRH changes introduced in Sierra Leone, 2002-2012

Numerous changes and reforms have been introduced in Sierra Leone between 2002 and 2012, without formal written policy documents. The most important shifts that took place during this period are described below.

HRH changes in the immediate post-conflict: 2002-2007

Policy objectives and approaches: Few documents recount the changes introduced with regards to the motivation, training, attraction and retention of HWs before 2009. Some documents indicate that between 2006 and 2007 the MoHS reviewed the existing Scheme of Service and introduced allowances for housing, hard-to-go areas, leave, and night work. Additionally, the Cabinet approved

the establishment of the Medical and Health Services Commission, in order to facilitate the absorption and promotion of HWs (later established as the Health Service Commission).

The information available is extremely limited and does not allow for a full analysis of the other sub-themes on the 'drivers of change', 'implementation', 'financing' and 'impact' of the reforms.

HRH policy changes introduced in preparation for the FHCI (2009-2010)

Policy objectives and approaches: In November 2009, the President launched the Free Health Care Initiative (FHCI) for pregnant and lactating women and young children under 5 years of age. Few months were given to the MoHS to prepare the implementation of the policy. HRH was included as a priority area and a series of HRH policy changes designed by the HRH sub-committee were introduced between November 2009 and March 2010:

- payroll verification and cleaning,
- fast-tracking recruitment and deployment,
- new Scheme of Service and salary increase.

An in-depth verification of the payroll was carried out to ensure that only legitimate staff were included in the MoHS payroll. The process was led by DfID-funded technical assistants, with the District Health Management Teams (DHMT) and hospital management staff. At the same time, a system for the fast-track recruitment of key staff cadres was put in place, along with that for the recruitment of retired HWs on fixed-term contracts. Finally, in March 2010 a revised Scheme of Service was introduced and salaries, which now include all standard allowances, were substantially increased.

Drivers of change: The urgency of the FHCI launch, alongside the political pressure for successful implementation of the initiative, played a major role in pushing the MoHS and its partners to approve and implement these HRH reforms. The involvement of the highest levels of government made the FHCI a key turning point, catalysing support for many health sector reforms, including HRH issues. International donors also supported the policy. The UK Department for International Development (DfID) committed to financially support the government in paying increased salaries, with the condition that the funds provided would benefit HWs on the ground, thus opening the door to (and providing technical assistance for) the payroll cleaning process. Along with DfID, the Global Fund (GF) provided the bulk of the funding to support the salary increase for HWs. However, there are no documents indicating the organisation's role in the policy formulation process, which is understood to be inconsistently engaged with the decision processes both during policy-making and implementation.

Implementation of policies: The documents analysed show that the implementation of HRH reforms was not free of challenges. Problems included a lack of communication between finance and HRH functions in the MoHS and little coordination of responsibilities between national and decentralised institutions. A key issue arose when HWs went on strike six weeks before the launch of the FHCI, mainly because of a lack of communication to the HWs on the new initiative and upcoming salary increase.

Financing of policies: During the first 3 years of FHCI implementation, DfID contributed 22% of the costs, GF 20% and the GoSL the remaining 58%. DfID also funded most of the technical assistance, in particular for the payroll management and attendance monitoring system described below.

Impacts: Some documents mention that as a result of payroll verification and cleaning, 850 phantom HWs were removed (around 12% of the total), while 1000 new HWs were added. However, other documents point out that 1,626 HWs were initially removed but then most of them were reinstalled. Only 297 HWs were permanently removed from payroll. The new recruits include HWs who were previously working 'voluntarily' in the facilities.

The salary increase was highly skewed towards the higher grades. While the aim of the salary increase was to attract HWs, reward them for their increased workload and replace informal fees, the disproportionately higher increase in the salaries of higher cadres (i.e. doctors) is not justified based on these objectives. With reference to HWs productivity, motivation and incentives, little research has yet been done to assess the impact of the reforms.

HRH policy changes introduced after the FHCI (2011-2012)

Individual performance management systems

Policy objectives and approaches: The introduction of a Sanctions Framework was discussed during preparation of the FHCI. However, it was it not ready for implementation by April 2010. The monitoring of staff absence started in mid-2010 via the Attendance Monitoring System (AMS) and January 2011, the Staff Sanction Framework was implemented, with the aim of reducing absenteeism among HWs.

Drivers of change: The introduction of the AMS and the creation of a Staff Sanction Framework were included in the FHCI priority actions and were one of the conditions indicated for DfID support. One of the main reasons for the delay of their implementation was its complexity and the difficulty in reaching an agreement between different bodies.

Implementation of policies: The approval of the framework did not find extreme opposition. Once approved, managing the AMS appeared challenging and quite time-consuming both at facility level and the MoHS headquarters. However, some suggest that the results were appreciated by frontline managers.

Financing of policies: The establishment of the Staff Sanction Framework did not require major costs. The HRH Support Unit, established within the HRH Directorate to assist with maintaining the integrity of the payroll, was also charged of supporting the Sanction Framework implementation, with DfID-funded technical assistance.

Impacts: The Staff Sanction Framework appeared to reduce unauthorised absence. The reported absence levels went down to 5.5% during 2011, though the spot checks suggest it may be actually higher.

Performance-based incentive scheme

Policy objectives and approaches: The consensus among donors on the need to better fund facilities, as well as the agreement on PBF as one of the best option to provide such funds, led to the introduction of a "Simple Performance-Based Financing Scheme for Primary Healthcare". The concept paper was presented to the MoHS by the World Bank on February 2010, and the operational manual was approved in March 2011, shortly before the implementation of the scheme on April 1st. The objectives of the PBF scheme are to provide money to facilities to cover the local costs of delivering services, removing the need for 'informal' fees, and providing financial incentives to staff in order to increase productivity and quality of care.

Drivers of change: The PBF scheme was a logical improvement to the pre-existing "cash-to-facilities" system. The scheme was also in line with the emphasis given to 'performance' and performance management strategies in Sierra Leone after the introduction of the FHCI.

There are no documents available that state the position of the donors, in particular the World Bank, who were providing funding and technical assistance for the scheme.

Implementation of policies and impacts: The PBF scheme was initially implemented in a "simple" form at PHU level, using only existing institutions and administrative arrangements (now extended to PCMH and Ola During Children's Hospital in Freetown). Little information exists on the functioning of the scheme, its effectiveness or the way it interacts with other existing incentives.

Remote allowance

Providing increased remuneration for HWs employed in remote areas to reduce attrition has been on the agenda of the MoHS for some time. The introduction of rural incentivisation was discussed as a priority during the preparation for the FCHI. However, such allowance was not established at the time. In January 2012, a Remote Allowance began being paid to HWs posted in rural areas, with funding from the Global Fund. No official policy documents were retrieved on the functioning mechanisms, and no information was found on the process that led to the design and approval of the strategy. Regarding its implementation, some issues arose in the second quarter of 2012 as payment slowed down, possibly because of cash-flow shortages.

Establishment of the Health Service Commission

The creation of a Health Service Commission (HSC) was envisaged to address the issues that still persist on the delays of the inclusion in payroll of new recruits. An evaluation found that of the 1,474 new employees recruited in March/April 2012 by the MoHS, only 8% (124) were on payroll by June 2012. However, there is little information available on the current functioning of the HSC.

Human Resources Information System

There is currently no relationship between Heath Information System (HIS) data and data collected manually on HRH. In 2011 MoHS requested the World Health Organisation (WHO) to support the establishment of a Human Resources Information System (HRIS) to keep track of all HWs. Work on this is currently ongoing.

Lessons and conclusions

How policies developed[1]: During the initial post-conflict period (2002-2009), solutions were proposed to address HRH challenges however, they were rarely implemented. In 2009-2010, the launch of the FHCI garnered strong political support. This political pressure to deliver results acted as a catalyst for the HRH reforms that had been proposed for years to finally come to fruition. These reforms made Sierra Leone one of the few countries to tackle key HRH problems and to explicitly address the link between the removal of fees and the income and incentives given to HWs.

After the momentum created by the FHCI, the implementation of HRH reforms seemed to slow down. Moreover, a disconnection between official policies and operational shifts can be noted as the HRH policies approved in 2012 followed the operational reforms as if making them official and organic without proposing new arrangements.

The country's conflict and post-conflict trajectory – its legacy and lessons for the future: The HRH policy trajectory in Sierra Leone shows the importance of a catalyst initiative to overcome the political uncertainty, build a momentum and create a wide support for radical reform of the health sector. Whether this policy-making 'pattern' could be described as typical or characteristic of a post-conflict context remains unclear. One conflict-related issue that emerges is the lack of capacity within the central institutions for the planning and effective implementation of reforms. This could account for the slow or non-implementation of reforms in the 2002-2009 period, and is also reflected in the high dependence on TA for the FHCI-related reforms. It is also possible that the post-conflict situation and the perceived need for radical, urgent changes (after some years of stalemate) resulted in more flexible power relations and dynamics between influential actors, which in turn allowed for radical reforms to be introduced. Another theme that seems characteristic of post-conflict contexts is the focus on 'performance', as it has been noted that many early PBF schemes have been introduced in post-conflict countries.

[1] see Figure 5 in main report.

The apparent success of Sierra Leone in addressing some of the HRH issues cannot, however, hide two facts: (i) that, possibly because of the urgency in the preparation of the FHCI, one-off exercises were preferred to more structural and sustainable reforms, and (ii) that only the most urgent, short-term issues were tackled (albeit important ones), while others, requiring more long-term solutions seems to be left for later on. In the future, the main challenge for Sierra Leone would be to maintain the political and financial support around health policies and reforms, despite the decreased attention and pressure around the FCHI. Existing policies will need to be evaluated and adapted accordingly, and new ones implemented.

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 on the incentives established for health workers (HWs) and their dynamics over the post-conflict period.

One of the most important components of a health service delivery system is the availability of adequate and skilled human resources (WHO, 2006). Paying and motivating HWs is as important as ensuring that enough HRH are available to provide the service. However, the commitment and performance of the health workforce depends on several factors including but not limited to: conditions of service, professional development, 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. Thus, with insufficient or no incentives, HWs may react by e.g. refusing to work in rural areas where they may not earn additional income from private practice or other sources. This could seriously affect the overall productivity of the health delivery system, particularly in remote areas of the country.

As indicated in our research proposal (ReBUILD & COMAHS, 2012), we have limited information on whether the HWs incentives in Sierra Leone are enough to motivate the health workforce to stay in their jobs, and on how to reach and maintain incentive environments for HWs to support access to rational and equitable health services. 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 Ministry of Health and Sanitation (MoHS) on the different mechanisms that can be used to attract staff into new contracts especially in remote settings and hard to reach areas. This is critical to the attainment of the vision of the MoHS.

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 in the shift away from conflict;
- To understand what influenced the trajectory;
- To describe the reform objectives and mechanisms and intended and unintended effects; 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 research of ReBUILD Project 2 is a retrospective and cross-sectional study, utilising both quantitative and qualitative methods. Both methods will complement each other in exploring the post-conflict dynamics for HWs. The timeframe for retrospective data collection will be the period since the end of the conflict in 2002 to the present day. The overall study is articulated around different methods and data collection tools. They include:

- a stakeholder mapping -- carried out in Freetown in October 2012 (Witter, Kosia, & Samai, 2012);
- a document review (present document);
- a series of key informant interviews;
- an analysis of existing quantitative data;
- a series of in-depth interviews/life histories with HWs; and
- a quantitative HW incentive survey (HWIS).

Objectives of the document review

The present document reports on the findings of the document review.

The objective of this review is to describe the HRH context in Sierra Leone and the HRH policies that have been introduced over the post-conflict period, in order to better understand the reasons for their introduction, how they have been implemented, and any effects of the policy changes during the post-conflict period.

In attempting to provide initial answers to this research question, the document review serves to illuminate future work of the ReBUILD team in Sierra Leone, guide the key informant interviews and provide clues on how and why certain HRH policies were developed and implemented in the post-conflict environment and what were their effects with reference to the country's HRH and health policy objectives.

It is important to note that this review is a 'working document' and the product of several rounds of data collection and compilation. Albeit extremely useful and instrumental for the next steps of the research project's analysis, it necessarily remains incomplete as new documents are retrieved or produced in Sierra Leone.

2. Research methods for the document review

Search strategy

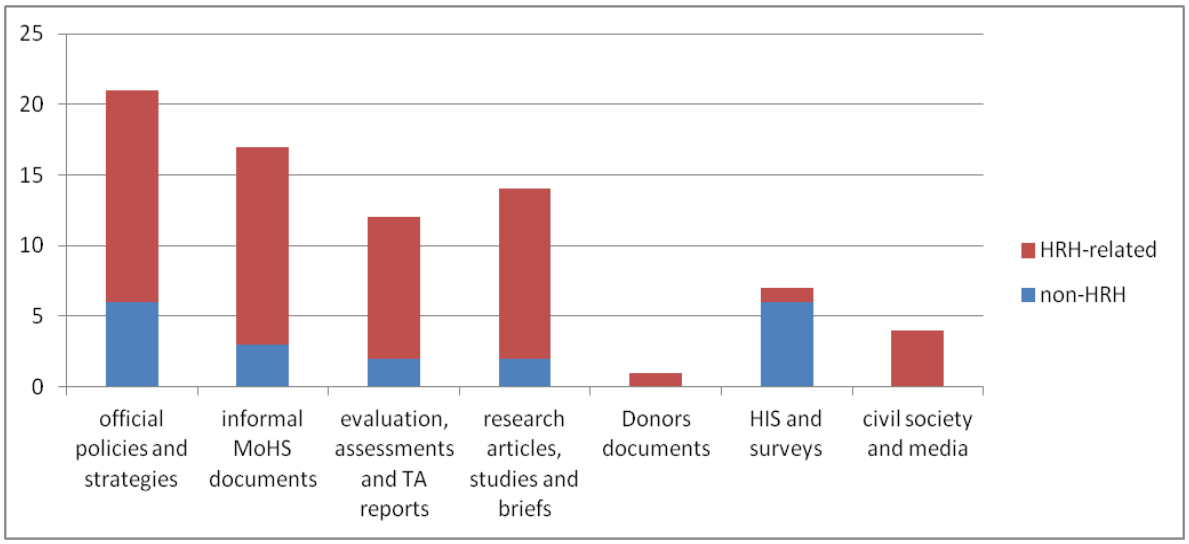
Documents were retrieved in 2012 by the COMAHS/ReBUILD team in Freetown, through contact with the Ministry of Health and Sanitation (MoHS), international donors and partners, other stakeholders and the international ReBUILD team during field visits and through interviews with informants both in Sierra Leone and in the UK. A rapid internet search was also performed to identify articles in peer-reviewed journals and other relevant grey literature. A snowball technique was then adopted by which documents mentioned in other documents were actively searched from the source. If a theme or policy seemed under-represented, new searches were performed. Any remaining gaps are highlighted in this report.

Number and type of documents

The initial search led to the identification of 76 documents (see **Annex 1**). After an initial screening, 57 were deemed relevant for HRH issues in Sierra Leone and have been fully reviewed (those highlighted in **bold** in Annex 1).

The majority of the 76 documents are authored by the MoHS and the Government of Sierra Leone (GoSL). 21 documents (28%) are official policies and strategies (including operational manuals) of the GoSL or of the MoHS, while 17 (22%) are informal documents of the MoHS, including internal communications, monthly updates, reports, extracts of documents, etc. With reference to other sources: 12 (16%) of the documents are evaluations, assessments of context, policies and technical assistance reports, while 14 (18%) are independent studies, briefs and research articles. Only 1 document is by an international donor, defining its operational plan. The rest are statistical reports (7 – 9%) and civil society and media publications (4 – 5%) (see figure 1).

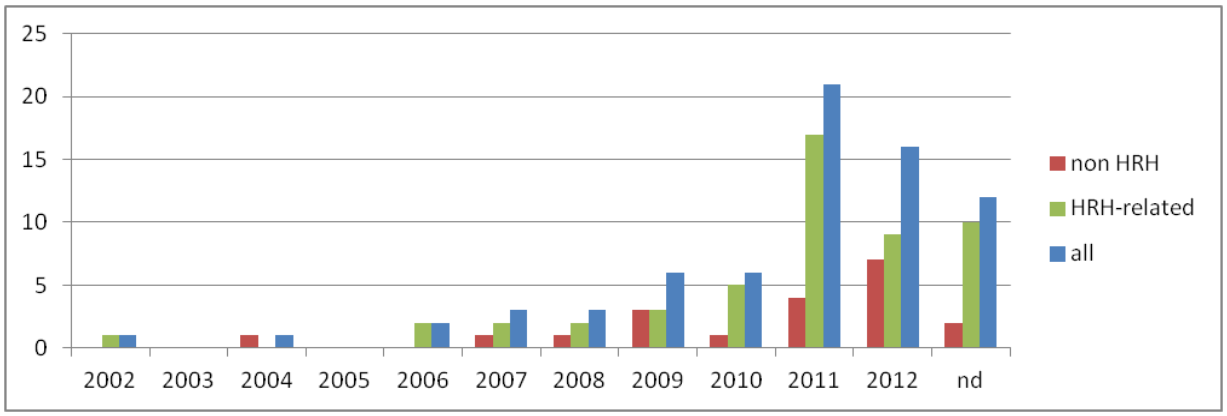
Figure 1: type of documents retrieved by subject



It is important to note that the oldest document available is dated 2002. There is another one from 2004, while the vast majority are from 2009 onwards, with 54% of the documents dated 2011-2012

and 16% undated (Figure 2). This may reflect the increased activity and investment levels in the sector post-2010 and/or the difficulty of retrieving earlier reports. Additionally, this may be because before 2009 many different actors were implementing projects in a somewhat uncoordinated manner, focusing on 'fire-fighting' and emergencies, without having time and resources for the production of policy documents.

Figure 2: date of publication of the documents retrieved by subject



Thematic analysis

In order to analyse the documents collected, a series of 'themes' were identified and validated by the team. Themes and corresponding subthemes are listed in Table 1. All documents were read and analysed, looking for reference to those themes with regards to each HRH policy[2] discussed and implemented in Sierra Leone after 2002. Comparison of policies pre-, during and post-conflict has been carried out, where documents permitted.

The use of common 'themes' and of a template for the drafting of the report was deemed useful in order to structure the analysis and write-up. This also allows comparability both across countries, as the same template will be adopted for the document reviews in other countries where ReBUILD focuses, as well as with other sources of information. In particular, the latter will allow triangulation of the information retrieved through the document review with that collected from key informants' interviews.

Table 1: Themes and subthemes 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	
	Drivers of change	
	Implementation of policies	
	Financing of policies	
	Impacts	

[2] For an explanation of the term 'policy' in this report, see section 3.2.1.

Study limitations and gaps

Although care was taken to search and include all relevant documents, the document search was not performed in a systematic manner and it is likely that some documents may have been omitted. Potential gaps in the document search, as well as information that should be verified and complemented either with other documents or by key informant interviews are highlighted in red boxes separate from the text. Such information will be useful to prepare new versions of this report, which is to be considered a 'working document' that will evolve as new information is collected, verified, coded and analysed.

In general, as captured in figure 2, very few documents refer to the HRH situation before and during the conflict. It is therefore difficult to describe the situation prior to 2009. Additionally, little information is available on the funding of the reforms, which makes it more difficult to provide a complete discussion of the theme 'financing of policies'.

Another important limitation of the documents is that most of them represent the 'end point' of discussions between different actors. Most of the documents included are official ministerial policies and technical assistance reports, assessing the situation or evaluating the implementation of policies. There is a general lack of documents, such as minutes from meetings, where the participation was large, including both Ministry and partners, which could highlight how different point of views were presented and debated before decisions were taken. The available documents are mostly 'static' and it is difficult for them to tell the story of how policies emerged and consensus was reached around their implementation. Key informant interviews will be critical to complete the accounts on this aspect and fill gaps under the theme 'drivers of change'.

Moreover, because the documents analysed are mainly from the MoHS, they tend to relate one side of the story, whilst donors and other stakeholders remains mostly silent. It is likely that the reason for the prevalence of policy and strategy documents is that they are official, publicly available and easy to access, while minutes are often buried in a few people's computers and difficult to obtain. Donors' internal documentation is generally not available or confidential. Again, key informant interviews will be fundamental to highlight other perspectives.

Key informant interviews will be critical to complete this document review and (i) illuminate further on the discussions, processes and dynamics that led to the development of the documents reviewed, and (ii) relate the perspective of other actors whose documents are not included, or that did not produce any written documents on the same issues.

Notwithstanding these limitations, the document review represents a useful initial step to advance the research work of ReBUILD Project 2 in Sierra Leone. It serves to guide key informant interviews and to help formulate hypotheses on how policies emerged, developed and were implemented. It also improves our understanding of the country's post-conflict trajectory with respect to HRH.

3. Findings

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

In this section, we present information about HRH in Sierra Leone and the main HRH challenges faced by the country during the war and in the aftermath. Despite pre-2009 documentation being scarce, we attempt to present all evidence collected from the earliest information available and to highlight the most important changes and developments until 2012.

Availability and retention challenges

An undated document from the HR Manager of the MoHS on the HR capacity challenges in the health sector (datable around 2006) reports on the availability of public medical personnel over the years 1993-2005 (MoHS, n.d.-a)[3]. The table clearly shows the sharp loss of qualified HWs from the public health sector during the conflict in Sierra Leone and the gap that remained to fill in. The main causes of attrition, during and after the war, were the deaths of HWs and migration for safety and better economic opportunities. Others joined the NGO sector as it was able to offer better working conditions (Sandi, n.d.). Those who stayed in the government service preferred to work in the capital or in the district headquarter towns (see below, "distribution challenges").

Table 2: availability of MoHS medical personnel: 1993-2005 (other data in **Annex 2**)

Specialization	Number in post				Established vacancy	Gap
	1993	2003	2004	2005		
Medical Officers	203	73	66	67	300	233
Surgeon Specialists	27	7	5	4	30	26
Physician Specialists	23	1	1	3	30	27
Paediatricians	5	3	3	3	20	17
Dentists	19	6	5	6	10	4
Obstetrician/Gynaecologists	22	8	7	6	30	24
Public Health Spec.	58	19	19	19	30	11
Haematologists	-	1	1	1	10	9
Radiologists	-	1	1	1	5	4
Anaesthetists	-	1	1	1	8	7
Psychiatrists	1	1	1	1	5	4
ENT Specialists	1	1	1	1	5	4
State Registered Nurses	623	266	112	152	600	488
Community Health Officers	-	-	132	152	500	348
State Certified Midwives	-	-	197	-	300	103
Pharmacy Technicians	-	-	91	228	400	172
SECHN	1014	712	653	753	1500	747

Source: MoHS HRD Survey, July 2004 cit. in (MoHS, n.d.-a)

The document recognises that the challenge to increase availability of HWs lays both in training of new HWs under a coherent national human resource plan, as well as in increased retention of

[3] It is important to note that other documents report different data on available HWs, thus revealing a general weakness in the completeness and quality of data, already mentioned by Newlands et al., (2011). We have referred to one source of data in the text, preferring the oldest ones. However, in **Annex 2**, we report alternative data on the same issue.

existing qualified staff by increasing job satisfaction and motivational factors, such as increased salaries, car loans and housing schemes, and ensuring the payment of other allowances (risk, extra-duty, remote area, etc.) (MoHS, n.d.-a).

The HRH Manager annual presentation in 2007 listed in details the causes for attrition (Sandi, 2007):

- poor conditions of service (low salaries, poor working environments, inadequate basic working equipment),
- no financial or non-financial incentives,
- poor career progression and slow promotion
- inadequate training opportunities,
- slow absorption processes,
- death as a natural cause,
- retirement (either voluntary or attainment of actual retiring age),
- migration for better economic opportunities,
- poor management style,
- poor appraisal system.

Most of these issues are analysed in the following sections.

Despite the policies and the important changes introduced in recent years to tackle these issues (cf. par. 3.2), the HRH situation remains dire. In 2011, the *HRH Country Profile* highlighted very high vacancy rates prevailing for health professional staff at MoHS (Table 3). Furthermore, the high vacancies seen in the technical grades also affect administrative staff, such as Hospital Managers (vacancy rate of 100%) and the Births and Deaths Registrar (82%) (AHWO, 2011)[4].

Table 3: MoHS Health Professionals (2011)

Staff Category	Authorised	No. in-post	Vacancy Rate
Specialists (includes in management position)	75	41	44%
Registrars (All)	70	5	93%
Medical Officers (All)	116	79	32%
House Officer	66	40	39%
Radiographer	16	0	100%
Physiotherapist	13	1	92%
Orthopaedics	52	18	66%
Rehabilitation	285	15	95%
Medical Electronic Engineer	26	0	100%
Medical Equipment Technician/Electrician	96	17	82%
Nutrition & Catering	318	54	83%
M&E	248	14	93%
Environmental Health Aide	540	171	68%
Maternal & Child Health Aide	2640	1892	28%
Nursing Aide/Assistant	1008	1098	+8%
Darkroom Attendant	56	n/a	n/a
Laboratory Aide/Attendant	221	78	65%
Pharmacy	412	197	52%
Medical Laboratory Science	685	183	73%
Refractionist	52	5	90%

[4] The *Sierra Leone HRH Country Profile* (AHWO, 2011) is a key reference for data on the current HRH situation, reporting important information including disaggregated by gender and age of HWs.

Community Health	839	566	33%
Epidemiology	29	1	97%
Health Education	284	5	98%
Environmental (Sanitary) Health	1029	200	81%
Nurses	4536	1746	62%
Midwives	400	76	81%
Senior Ward Sister / Midwifery Officer	100	6	94%

Source: Personnel Unit MOHS (October, 2011) cit. in (AHWO, 2011)

The calculation of vacancy rates is based on 'staffing norms', i.e. how many HWs and which cadre are envisaged to work in each type of facility. Currently, such norms are based on the *Basic Package of Essential Health Services for Sierra Leone,* which provides guidelines on the staffing of some health facilities (MoHS, 2010: p. 21). Other documents presenting 'staffing norms' do not seem to be available. Therefore, it is not clear how vacancy rates were calculated before 2010.

Distribution challenges

No information is available on the geographical distribution of the HWs before 2010-2011. Recent data reveals that the deployment of HWs, which is under the control of MoHS at central level, is highly skewed to urban areas, particularly towards the capital Freetown in the Western region (table 4). Concentration curves and indices (**Annex 3**) for HWs in the public, private and NGO sector confirm the skewed distribution, with the exception of NGO sector where staff distribution appears to be more equal, reflecting the strong rural presence of NGOs (Newlands, Ensor, & McPake, 2011). As a consequence, the availability of higher level professional health cadres outside of the Western Area is extremely low and the health system has to rely on maternal and child health (MCH) aides for the delivery of reproductive, maternal and newborn healthcare. These staff are not considered skilled birth attendants according to international standards (Oyerinde et al., 2011 cit. in Newlands et al., 2011).

Table 4: Distribution of publicly-employed medical officers (2011) and SRNs (2010)

District	Population (2011)	MOs (2011)	MOs/ 100,000 pop.	SRNs (2010)	SRNs/ 100,000 pop
Kambia	433,203	2	0.46	2	0.46
Koinadugu	612,276	3	0.49	6	0.98
Pujehun	608,730	3	0.49	3	0.49
Port Loko	404,244	2	0.49	7	1.73
Bombali	518,307	3	0.58	7	1.35
Moyamba	317,958	2	0.63	3	0.94
Kailahun	314,412	2	0.64	3	0.95
Tonkolili	312,048	2	0.64	1	0.32
Kenema	461,571	3	0.65	4	0.87
Kono	256,494	2	0.78	3	1.17
Bo	300,228	3	1	9	3
Bonthe	156,615	3	1.92	0	0
Western	1,219,233	24	1.97	109	8.94
Total	**5,910,000**	**54**	**0.91**	**157**	**2.66**

Source: (Newlands et al., 2011)

HRH production challenges

Very few documents describe the HRH training situation before and during the conflict. A 2006 (?) MoHS HRH document laments the lack of a coherent national human resource plan, which leads to training based on personal rather than corporate needs (MoHS, n.d.-a).

The *HRH Country Profile,* referring to the situation in 2011, reports that the Government of Sierra Leone (GoSL), through the Ministry of Education, Science and Technology and the MoHS, currently owns 7 of the 12 pre-service training schools. The largest school is the College of Medicine and Allied Health Sciences (COMAHS), which offers training across nine disciplines. Njala University College in the Southern Region focuses on four disciplines. The two universities belong to the Ministry of Education, Science and Technology. There are 4 private training institutions ran by the Christian Health Association of Sierra Leone (CHASL), focusing mainly on the production of state enrolled community health nurses (SECHN), while the private for profit sector has one school to train SECHN. In terms of geographical distribution, the highest concentration of schools is in the Western Area (5), while each of the other three regions has two schools or more. Midwifery training is provided only in the Northern Region and the Western Area (AHWO, 2011).

Beyond the low availability and maldistribution of training institution, there are some issues regarding the training curricula. Training for medical doctors and nurses is clinically-oriented, rather than focused on public health. Some experts have pointed out that most of Africa's disease burden can be addressed by community health nurses. Yet Sierra Leone continues to emphasize training of diploma/degree-level nurses (registered nurse) rather than the community health nurse (enrolled nurse. The programme to become a registered nurse can take 3-4-years and is expensive whereas the training is shorter (2.5 years) and less expensive to become an enrolled nurse (ReBUILD, n.d.). The research done for the *HRH Country Profile* also showed that Ministry of Education, Science and Technology institutions, as well as private ones, do not discuss training targets for all disciplines of health staff with the MoHS and sets their own targets based on internal capacity. Therefore, until 2011, there was no central coordination of training and no unified effort to meet the workforce training needs of the country (AHWO, 2011). To make matters worse, students meeting the minimum requirements for admission into the health training institution (and particularly for medicine, nursing and pharmacy) are few (MoHS presentation, 2012).

Recruitment and deployment challenges

In Sierra Leone recruitment of HWs is done centrally and the process involves a high degree of bureaucracy. Currently, applications are received by the MoHS at central level and are forwarded to the Human Resource Management Office (HRMO). HRMO then processes the applications and, if the applicants meet the minimum requirement for the job, it forwards them to the Public Service Commission (PSC), which then summons the applicants for interview. The PSC then sends back the results to HRMO and orders it to appoint the successful applicants. The HRMO informs the Department of HRH (DHRH) in the MoHS and the DHRH opens a file and deploys the new employee (AHWO, 2011; ReBUILD & COMAHS, 2012). Deployment is done centrally by a posting committee within the MoHS headed by the Chief Medical Officer (AHWO, 2011).

The recruitment process is lengthy (3-6 months) and the MoHS needs the approval of two bodies outside its control (i.e., the HRMO and the PSC). This delay in recruitment, as well as the fact that employment in the public sector is not guaranteed for all graduates, disincentivises HWs and can lead to young health professionals leaving Sierra Leone long before they are appointed (AHWO, 2011; ReBUILD & COMAHS, 2012). Other HWs choose to work in facilities without a civil service contract and regular salary (i.e. as volunteers), in the hope of being eventually included on to the

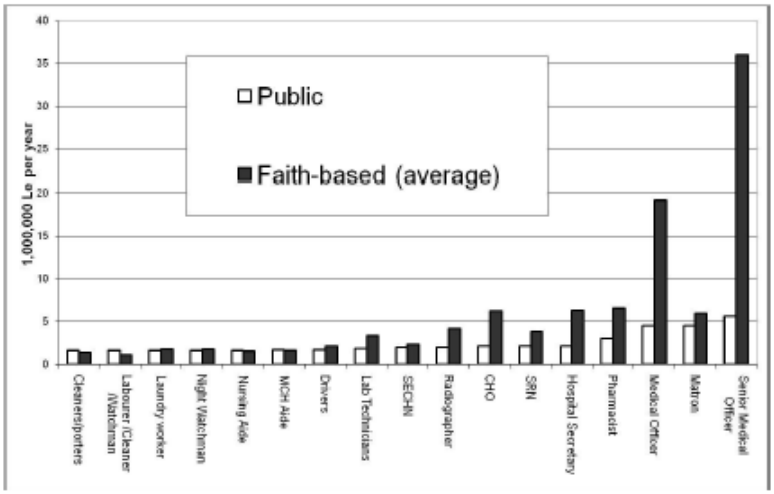
payroll and because of what they can earn (officially and unofficially) directly from patients (Ensor, Lievens, & Naylor, 2008). Changes to this centralized recruitment process are envisaged for 2012 with the creation of the Health Service Commission, as described in section 3.2.3.

Performance challenges

Factors influencing the motivation and the performance of HWs include the salary, the presence of other financial and non-financial incentives, management, and clear career progression.

Prior to the conflict, HWs' salaries were often paid irregularly (at least until September 2004) and were appallingly low (Ensor et al., 2008). In the immediate post-conflict period, NGOs and other humanitarian organizations did not only provide emergency health services, but also gave financial incentives to certain cadres of HWs working in rural and remote areas. When these organizations left, the government was not able to maintain the same incentive environment (ReBUILD & COMAHS, 2012). Important disparities remain between salaries in the public sector and what can be earned outside of the civil service, particularly for the most skilled professionals. A comparison between the public and faith-based sector found 4 to 7-fold differences for senior medical officers (Figure 3) (Ensor et al., 2008).

Figure 3: Comparison of remuneration for selective staff categories (faith-based and public sector)



Source: Ensor et al., 2008 - from payroll data of MoHS and selected faith-based hospitals

Additionally, HWs are initially given a non-pensionable temporary appointment. Only after working for one year are they appointed into a permanent pensionable scheme with additional benefits, such as study leave and annual leave. Depending on their rank, HWs are also provided with certain benefits (e.g. housing, transportation, payment for medical bills abroad, telephone top up cards). However, the vast majority of the HWs do not benefit from such incentives (ReBUILD & COMAHS, 2012).

In recent years, and in particular since the introduction of the Free Health Care Initiative (FHCI) in April 2010, a series of HRH changes were implemented. These included an increase in HWs' salaries, the introduction of a Staff Sanction Framework to reduce absenteeism, and the implementation of a Performance-Based Incentive Scheme in Primary Healthcare Units (PHUs). These reforms are critical in contributing to the motivation and the performance management of HWs and are reviewed in more details in the following section (par. 3.2.3).

In regards to career path, specialist HWs are promoted on the basis of performance record and according to competence, qualifications and experience (MoHS, 2006a). Career progression for doctors is as follows:

- House Office (HO),
- Medical Officer (MO),
- Senior Medical Officer (SMO),
- Registrar
- Senior Registrar
- Specialist,
- Senior Specialist,
- Consultant,
- Deputy Chief Medical Officer (DCMO), and
- Chief Medical Officer (CMO);

and for nurses:

- Nurse,
- Staff Nurse,
- Sister,
- Senior Sister,
- Assistant Matron,
- Matron,
- Deputy Chief Nursing Officer, and
- Chief Nursing Office.

However, currently there is a lack of career progression for other cadres of health worker, such as CHOs and CHAs(ReBUILD, n.d.).

Information on other important elements regarding the performance of HWs, such as data on over time/hours worked, absenteeism, dual practice, responsiveness to patients, or technical quality of care are not available (though some may be commissioned as part of the forthcoming evaluation of the FHCI).

HRH governance challenges

Until 2011, the MoHS had a department for human resources which was in charge of dealing with all issues relating to HRH. The limited capacity within the MoHS to deal with HWs challenges limits the effectiveness of the HRH function (AHWO, 2011). In 2011, the HRH unit was upgraded to a directorate (AHWO, 2011; MoHS, 2012a). However, despite the restructuring that took place to strengthen it, most HRH policies come from the HRMO in collaboration with the Public Service Commission, with the DHRH operating as an implementation unit with limited input into the MoHS's strategic planning process (AHWO, 2011).

While there is a decentralisation process in place, at district level there is no HRH unit and the personnel administration is left to the general clerks. HRMO is the only body with the authority to terminate contracts (others can only recommend it). Councils are not responsible for paying HWs. They can at most recommend them for promotion (AHWO, 2011).

1.2 Policy responses

1.1.1. Definition of 'policies'

In this section, we analyse the documentation collected with reference to the HRH policies introduced in Sierra Leone. We use the term 'policy' in a very broad sense, including not official policies and strategies on HRH, but also changes that affected HWs, which were approved in an alternative form to an official policy document.

A series of HRH policies and changes in the management of HWs have been introduced over time in the attempt to address the issues highlighted in the previous sections. As described above, given the difficulties to retrieve documents predating 2002 and the end of the conflict, we focus only on HRH reforms that took place from 2002 onwards (largely 2009 to present). We divided the discussion into two main sections, one relating to official policy documents (section 3.2.2) and the second analysing the documentation on the most important HRH shifts (section3.2.3).

1.1.2. Evolution of the official HRH policies in Sierra Leone

Description of policy objectives and approaches

The first *National Health Policy* (NHP) of post-conflict Sierra Leone (MoHS, 2002) mentions the availability of healthcare professionals among the priorities for the sector. It recognises the insufficient number of HWs, their maldistribution and it also proposes ways of addressing issues such as the financial motivation of HWs, the regulation of private practice/NGO's incentives compared to the public sector, and the training needs for the HRH. However, the NHP did not indicate precise solutions or actions to address these problems but rather suggests that they should be addressed in a subsequent HRH Plan.

Subsequently, the *Human Resources for Health Development Plan 2004-2008* was developed in 2004 and revised in 2006 (MoHS, 2006b). This was followed by the development of the *Human Resources for Health Policy in Sierra Leone* in 2006 (MoHS, 2006a).

The document available is the *Revised Human Resource for Health Development Plan 2004-2008*, dated 2006 (MoHS, 2006b). The original *Human Resource for Health Development Plan 2004-2008* has not been located.

Both documents begin with an analysis of the situation and challenges, and suggest a framework to *'organize consistent decisions regarding the supply, utilization and deployment of appropriately trained staff'* (MoHS, 2006b). In summary, they focused on:

- reinforcing HRH planning;
- strengthening the role of decentralized structures (as per the *Local Government Act* (GoSL, 2004));
- ensuring the training of sufficient HWs;
- experimenting with mechanisms for HW retention, particularly in rural areas[5];
- improving the HRH management structure i.e. the introduction of a Human Resources Information System (HRIS), personnel records, reviewed job descriptions, and payroll cleaning;
- ensuring better management of changes and the development of communication strategies.

[5] However, the definition of such mechanisms as salaries, allowances and other benefits were left to the Public Service General Orders by the *HRH Policy 2006.*

The *HRH Policy 2006* remains a relatively vague normative framework rather than an operational document, as exemplified by the recurrent use of the verb "shall"[6]. Despite allowing a certain flexibility to the activities proposed *'given the current level of uncertainty regarding the exact nature of the reforms and the detailed staffing requirements to support the National Health Policy'*, the *HRH Development Plan 2004-2008* describes precise targets for training and retention with reference to each cadre of HW, and a prioritization of such cadres (MoHS, 2006b).

The new national health policy, entitled the *Sierra Leone National Health Sector Strategic Plan 2010-2015* (NHSSP), was approved in 2009 (MoHS, 2009). The document is organized around the six building blocks of the health system (WHO, 2007), which include human resources for health. It identifies the main HRH challenges, gives a policy statement *('The Ministry of Health & Sanitation will implement the human resource policy and strategic plan that has mapped out the current situation and future staffing needs across the whole health sector and use trend analysis to identify the likely situation over the next 10 years'* - MoHS, 2009: 26), and embeds it in a strategic plan with objectives, articulated in actions and targets.

Table 6 provides an overview of its objectives and targets. These remain mostly programmatic, referring to the development of new plans and policies e.g. by recommending the preparation of a new HRH policy and a revised HRH strategic plan or management capacity strengthening. A few 'targets' are somewhat more pragmatic, such as *'fast track the recruitment process and improve retention for HRH'* or '*define career paths and incentive packages'*. However, quantitative targets are not indicated and even these propositions remain vague in terms of operational implementation of actual changes.

As envisaged by the NHSSP, the new *Human Resource for Health Policy* (MoHS, 2012a) and *Human Resource for Health Strategic Plan 2012-2016* (MoHS, 2012b) were developed in 2012. These documents are heavily influenced by the changes that took place since 2009, both in HRH strategies and approaches, and across the health sector in general. The most important change was the introduction of the Free Health Care Initiative, announced in November 2009, and its launch in April 2010 (GoSL, 2009). The FHCI represented a turning point for the health sector and for HRH. The changes in HRH strategies are described in detail in the following section.

Additionally the MoHS and its development partners signed the *Health Compact* (GoSL, 2011a) in December 2011. This document describes a framework for the coordinated efforts of Government and donors towards the implementation of the NHSSP through a sector-wide approach and establishment of a Health Sector Coordinating Committee, a Health Sector Steering Group and a series of Technical Working Groups. In January 2012, the *Joint Program of Work and Funding 2012-2014* (JPWF) (MoHS, 2012c), was developed. This was a medium term expenditure framework (MTEF) that evaluates the financial resources necessary to implement the NHSSP.

The *HRH Policy 2012* and the *HRH Strategic Plan 2012-2016*, aim to respond to the implementation challenges and priorities expressed in the NHSSP, the 'Compact' and the JPWF. The overall objective is to *'prioritize the retention and reverse the high attrition rates of qualified and experienced health workers and ensure continuous availability of health workers in sufficient quantity and quality [...]'* (MoHS, 2012a: 1). The 2012 policy acknowledges the creation of the HRH Department in 2011 and

[6] For example, regarding financial and non-financial incentives, the *HRH Policy 2006* establishes that, *'The Ministry, together with District Councils, shall establish clear staff motivation strategies to ensure continuity of service delivery. In addition to remuneration, loan and allowance packages, the ministry shall package non monetary incentives for its employees such as subsidized housing, furniture, clear reporting lines, relevant and suitable management style and counselling services. It shall also explore other strategies for retention of its employees'* (MoHS, 2006a: 17).

changes in the policy formulation process via the Health Sector Steering Committee and the HRH Technical Working Group, established by the *Health Compact*. The document gives policy direction in the six key HRH policy areas for action (i.e., governance, production, management, information and research, partnership, and mobilization of resources), and introduces concepts in the management of HWs, such as "performance assessment methods". In addition, a costed *HRH Strategic Plan* has been produced, the implementation of which will be led by the HRH Directorate.

Indeed, the *HRH Strategic Plan 2012-2016* is based on the same key policy areas[7] that are further developed to give a clear road map, including quantitative targets, a time frame and financial needs. However, the majority of those targets refer to the "plan", "development", "preparation" of strategies and reforms (terms actually used in the matrices of the plan), rather than to the actual implementation of such interventions.

Drivers of change

The nature of the documents reviewed in this section, i.e. official policies of the MoHS, makes the identification of the possible 'drivers of change' quite complex. Less official and 'intermediate' documents or oral reports on the debates that preceded the approval of these official documents could further illuminate on the processes of policy making and the role of the different actors involved.

This notwithstanding, the analysis of the official policies shows how official documents continue to highlight similar challenges and describe similar solutions, while they rarely propose actual implementation plans for the interventions. Such operational plans are normally postponed to a subsequent document, which usually leaves the options for implementation vague or open for a further clarification in yet another document. This highlights the extreme fluidity and variability -- and even "uncertainty" in the words of the 2006 revision of the *HRH Development Plan 2004-2008* - of the context in the immediate post-conflict reconstruction period (2002-2009).

One could argue that the 2012 documents (MoHS, 2012a, 2012b), which followed the launch of FHCI in 2009-2010, were prepared to give *ex-post* an official and organic shape to the reforms and changes that had already taken place at operational level in HRH strategies (section. 3.2.3), rather than to suggest a new policy.

Implementation of policies

As the *HRH Policy 2012* recalls, *'there have been two attempts to formulate national policy to guide the development and management of Human Resource for Health in Sierra Leone [...], but none was finalized or adopted for implementation*' (MoHS, 2012a: 6). Little was done prior to 2009 to implement the solutions proposed. The situation has changed since then, with the approval of the NHSSP and the launch of the FHCI, as well as of the related HRH reforms that are further analysed in section 3.2.3.

Financing of policies

A similar analysis can be also done for the financing of HRH policies before 2009, as little or nothing was done to guarantee the funding of the propositions advanced in the HRH documents. After 2009-2010, as the implementation of reforms became more coherent and operational, budgeted plans and expenditure frameworks began to appear. However, in the costed *HRH Strategic Plan 2012-*

[7] In fact, the *HRH Strategic Plan 2012-2015* is organized in 5 Policy Areas, i.e. Leadership and Governance, Training, Management, Information and Research, and Partnership (Advocacy and Resource Mobilization, which was included in the *HRH Policy 2012,* is missing).

2016, the majority of costs included referred to planning activities (including technical assistance, office work, meeting and materials) rather than the implementation of the intervention. One of the few budget lines accounting for implementation costs is the *'3.1.4 Staff remunerated: 345,396,811 USD'*, while others (i.e. *"3.5.2 Negotiate for competitive salary benchmarks [...]"* and *"3.5.4 Recruiting additional health workforce [...]"*) are left with no costs. No details are given on the repartition of such sums between GoSL and partners, or on the sustainability of the financing.

The JWFP, whose approval preceded the HRH Strategic Plan, provides a very detailed work plan (logical framework) with a precise list of activities. However, the budget needs are aggregated by sub-objectives as seen in Table 5.

Table 5: budget requirements for strategic objectives relating to HRH, 2012-2014.

Output	Cost in USD			
	2012	2013	2014	Total
Total	**34,847,859.09**	**35,389,910.00**	**38,320,413.00**	**108,558,182.09**
Strategic Objective 3.1: To provide and maintain a policy and strategic frame-work to guide HR development and management				
3.1.1 HRH Policy developed	220,709.09	0.00	0.00	220,709.09
3.1.2 HRH Strategic plan developed	104,350.00	0.00	0.00	104,350.00
3.2.1 HR Structure reviewed to effect HR functions	9,945.00	0.00	0.00	9,945.00
3.2.2 Integrated HRH information system as part of the HMIS developed and maintained	458,255.00	0.00	0.00	458,255.00
Strategic Objective 3.2: To strengthen the institutional capacity of HRH policy, planning and management				
3.2.3 Integrity of the payroll maintained	25,027,700.00	26,253,570.00	27,566,248.50	78,847,518.50
3.2.4 Adequate resources availed for staff remuneration	0.00	0.00	0.00	0.00
3.2.5 TA funding pool developed	5,050,000.00	5,302,500.00	5,567,625.00	15,920,125.00
Strategic Objective 3.3: To enhance the capacity of training institutions for health workers and build partnership with other Stakeholders				
3.3.1 Joint programme for capacity building & accreditation signed and imple-mented	1,009,800.00	101,640.00	7,497.00	1,118,937.00
3.3.2 Midwives trained and deployed	337,500.00	354,375.00	372,093.75	1,063,968.75
Strategic Objective 3.4: To upgrade and enhance competencies and perform-ance of health workers				
3.4.1 Performance appraisal & motivation scheme, including defined career path & incentive package, institutionalized.	0.00	26,460.00	1,117,053.00	1,143,513.00
3.4.2 On-the -job training, mentoring and shills development schemes introduced and implementation commenced.	1,070,800.00	1,105,125.00	1,160,381.25	3,336,306.25
3.4.3 Health Sector staff trained in post-basic education	750,000.00	1,250,000.00	1,500,000.00	3,500,000.00
3.4.4 Special trainings provided to identified programmes	674,000.00	854,700.00	880,897.50	2,409,597.50
3.4.5 Access training for health workers (nurses/CHOs) provided	20,300.00	21,315.00	22,380.75	63,995.75
Strategic Objective 3.5: To promote research into HRH interventions to provide evidence-based information for the improvement of service delivery				
3.5.1 HRH research conducted and research report disseminated on time	114,500.00	120,225.00	126,236.25	360,961.25

Source: (MoHS, 2012c)

Impacts

Given that most of the HRH policies have only been partially implemented or have not been implemented at all, it is not surprising that there is a lack of impact evaluation. The only document available is the *2010 Performance Report*, which assesses progress made in the first year of implementation of the NHSSP, cited in Newlands et al. (2011). The nature of the NHSSP targets means that the focus is on progress instead of impact on the availability and quality of HRH or the health status of the population (Table 6).

The *2010 Performance Report* shows progress on most objectives, in particular those relating to the preparation of policy documents, the fast-track recruitment and retention of HWs, and the motivation of HWs. It is worth noting that progress on recruitment, retention and motivation reforms is linked with the launch and implementation of FHCI. Some commentators propose that the NHSSP was the policy base for the launch of FHCI (Newlands et al., 2011).

Table 6: Progress on 2010 targets of the HRH pillar of the NHSSP

Strategic objectives	Targets	Actual progress
Provide and maintain a policy and strategic framework to guide HR development and management	A comprehensive HRH policy in place that is in harmony with major HRH stakeholders and national policies by 2010	Partially achieved
	A revised HRH strategic plan in place that is based on flexible and sustainable HRH projections by 2010	Partially achieved (HRH strategic plan is being reviewed by the Directorate of HRH)
	Fast track the recruitment process and improve retention for HRH, including special packages for hard to reach areas	(Partially achieved) revised the salary structure of entire health workforce and subsequently scaled up recruitment for the implementation of the Free Health Care Initiative in 2010; remote area allowance to be implemented under the Global Fund project
	Develop and implement a comprehensive training plan	Not achieved
Strengthen institutional capacity for HR policy, planning and management	An integrated HRH information system as part of the HMIS in place whereby health managers at appropriate levels keep the HR inventory up-dated and maintained	Not achieved (only a scoping mission complete)
Enhance capacity and relevance for training of health workers, in partnership with other stakeholders	Strengthen the capacities of health worker training institutions/ programmes and introduce accreditation schemes	Partially achieved
	Strengthen training management capacity at national and institutional levels in collaboration with partners in human resource development	Not achieved
Upgrade and enhance competencies and performance of health workers	Health worker motivation schemes, including defined career paths and incentive packages institutionalised at central level and all DHMTs	Partially achieved (Performance Based Financing established at primary health care level); health worker scheme of service has been developed but is yet to be finalized by HRMO
	Continuous training programmes introduced in various priority areas of work	Not achieved
	On-the-job training, mentoring and skills development schemes introduced and implementation commenced in all DHMTs	Partially achieved
Promote research into HRH interventions to provide evidence-based information for the improvement of service delivery	Establish functional partnership with research institutions and other relevant stakeholders	Not achieved

Source: Health Sector Performance Report, June 2010, cit. in (Newlands et al., 2011)

1.1.3. HRH policy changes introduced in Sierra Leone, 2002-2012

Beyond the official policies relating to HRH issues, numerous changes and reforms were introduced in Sierra Leone between 2002 and 2012 that affected HWs. The most important shifts that took place during this period are listed in Table 7. In the sections below, each of these changes is described and analysed separately.

Table 7: HRH policy changes in Sierra Leone, 2002-2012

Par.	Policy change / Reform	*Date*
a	• Review of Scheme of Service • Definition of allowances as % of salary	*2006-2007*
b	• Payroll verification and cleaning • Fast-tracking recruitment and deployment • New Scheme of Service and salary increase	*February-March 2010*
c	Individual performance management systems: • Staff Sanction Framework • Performance Management Contracts • Individual Performance Appraisal System	 *January 2011* *January 2011* ---
d	Performance Based Incentive Scheme	*April 2011*
e	Remote allowance	*January 2012*
f	Establishment of the Health Service Commission	*May 2011 (not fully functional)*
g	Human Resources Information System	---

a. HRH changes in the immediate post-conflict: 2002-2007

Description of policy objectives and approaches

Very few documents recount the changes introduced for the motivation, training, attraction and retention of HWs before 2009. However, a cabinet paper presented to the Cabinet by the Minister of Health and Sanitation (MoHS, 2007) and the annual presentation of the HRH Manager (Sandi, 2007) indicated that, between 2006 and 2007, the MoHS has:

- reviewed the existing Scheme of Service[8] and developed new ones to ensure a clearer career path;
- endorsed that 30% of basic monthly salary should be paid as a housing allowance to HWs who are not residing in government quarters in Western Area and district headquarter towns and 20% to others outside those areas,
- endorsed that 10% of basic monthly salary should be paid as hard-to-go area allowance, 10% of annual salary as leave allowance, and 2.5% of basic monthly salary as a night allowance;
- endorsed that a car loan should be provided to specific categories of personnel.

Additionally, in the documents mentioned above the MoHS invited the Cabinet to approve these measures and the establishment of the Medical and Health Services Commission, in order to facilitate the absorption and promotion of HWs. These measures were approved by Cabinet, which subsequently led to the establishment of the HSC.

[8] The Scheme of Service is a document that lists the ToR and the pay scale/grade for every cadre in the MoHS. Cadres are currently based on level of training.

The information available on the policy changes before 2009 is extremely limited and does not allow for a full analysis of the other sub-themes on the 'drivers of change', 'implementation', 'financing' and 'impacts' of the reforms.

b. HRH policy changes introduced in preparation for the FHCI (2009-2010)

Description of policy objectives and approaches

In November 2009, the President Ernest Bai Koroma announced his intention to launch the FHCI for pregnant and lactating women and young children under 5 years of age (GoSL, 2009)[9]. In the document describing the vision for the new initiative, HRH are included as a priority area. More specifically, the document refers to:

- improving conditions of service for health personnel, by introducing performance-based incentives for HWs in 2010, as well as rural incentives and establishing a Health Service Commission.
- providing adequate number of qualified HWs; in the short-term by deploying foreign doctors (Cuban and Nigerian) and training of MCH Aides and CHOs; in the long-term by establishing new MCH Aide and Midwifery training schools and a second medical school at Njala University.
- introducing improved and regular training programmes in management, public health and midwifery (GoSL, 2009: 9).

Very little time (approximately 5 months) was given to the MoHS partners to prepare the operational implementation of the new policy and budget. 6 technical sub-committees were established based on the six pillars of the NHSSP. These committees held regular meetings to identify challenges and find solutions to address them to ensure the smooth implementation of the policy.

As a result, a series of HRH policy changes took place between November 2009 and March 2010 in preparation for the FHCI. In this review they have been grouped together in the analysis as they were discussed and implemented at the same time. This section includes:

- payroll verification and cleaning,
- fast-tracking recruitment and deployment,
- Scheme of Service and salary increase.

It is important to highlight that other reforms, namely the performance-based incentive scheme, the rural incentive scheme and the conduct and sanctions framework, were also considered priority actions (GoSL, 2009; Heywood, 2010). However, because these policies were launched almost one year after the FHCI, they will be reviewed separately.

An in-depth **verification of the payroll** was carried out to ensure that only legitimate staff were included in the MoHS payroll. The process was led by Technical Assistants (TA) from Booz & Co. (DfID-funded) assisted by the DHMT and hospital management staff (Heywood, 2010). To ensure the longer term sustainability of this work, the payroll was reengineered to ensure that it remains clean and up-to-date so that the staff on payroll will continue to have accurate recording of designation, district and duty station (Heywood, 2010).

[9] There had been an attempt to eliminate user fees in Sierra Leone in 2005, which had failed because the government could not enforce the law and informal fees replaced formal ones (Scharff, 2012).

At the same time, a system for the fast-track **recruitment** of key staff cadres was put in place. In addition, retired HWs were also recruited on fixed-term contracts to face the sudden increase in service utilisation that was envisaged after the launch of the FHCI. With support from TA, HRMO and DHRH worked together focusing in particular on the recruitment of grades 1-5 HWs (i.e., the lower levels of HWs) (Heywood, 2010). These personnel were then **deployed** to the areas of greatest needs.

Finally, in March 2010, a **revised Scheme of Service** was introduced (MoHS, n.d.-b). This involved a revision of the job descriptions for MoHS staff (MoHS, n.d.-c) which was categorised in a 14-point scale corresponding to different salary levels and a substantial **increase in pay**, which now includes all standard allowances. The pay lift applied only to technical and clinical staff and not to administrative and supportive staff, whose salaries may be reviewed under a wider Public Sector Pay Reform.

Drivers of change

It emerged from the analysis of the timing of the reforms that the urgency of the upcoming launch of the FHCI, alongside the political pressure for a smooth and successful implementation of the initiative played a major role in pushing the MoHS and its partners to approve and implement these HRH reforms. The involvement of the highest government levels made the FHCI a key turning point, catalysing support for many health sector reforms including HRH issues. The President was directly involved in the support of the initiative, which was included under his flagship projects. Along with the MoHS, the restructured and reinforced Strategic Policy Unit (SPU), an influential high-level advisory unit in charge of promoting the presidential agenda and accountability, was also critical in managing the introduction of the reform (Scharff, 2012).

The most prominent donors, such as the UK Department for International Development (DfID), also supported the policy. DfID, together with the World Bank, the European Union and the African Development Bank, provides 80% of the total development assistance to Sierra Leone and reports to be a strong supporter of the FHCI as it responds to a clear and urgent crisis as reflected by some of the worst maternal mortality figures in the world (DfID Sierra Leone, 2011: 5). According to Scharff et al. (2012), DfID played a key role in the introduction of at least two important HRH reforms: financially supporting the government in paying increased HW salaries and conditioning this support on the assurance from the MoHS that the funds provided would benefit HWs on the job, thus opening the door to (and providing technical assistance for) the payroll cleaning process.

No information is available on the position of other donors and implementation partners on these HRH reforms. Along with DfID, the Global Fund (GF) provided the bulk of the funding to support the salary increase for HWs. However, there are no documents indicating the organisation's position and role in the policy formulation process, which was understood to be inconsistently engaged with the decision processes both during policy-making and implementation. The evaluation team in charge of assessing the HWs support from DfID found that there are no specific lessons to be learned from the GF decision-making process (Stevenson, Kinyeki, & Wheeler, 2012). Among the other key donors, the World Bank is described as initially critical in introducing the FHCI (Scharff, 2012), but no documents refer its position later on and on HRH issues specifically.

It is also interesting to reflect on the role that evidence played in driving the policy formulation process. The DfID Operational Plan 2011-2015 includes their support for the FHCI among the interventions for which national data is available, but the local evidence base is weak. The document explains that, *"[the] support to the Government of Sierra Leone's Free Health Care Initiative is*

responding to a clear and urgent crisis as reflected by some of the worst maternal mortality figures in the world. The choice of intervention was innovative and therefore does not have a strong local evidence base. As a result DFID are undertaking a full impact assessment to develop the evidence base as the programme progresses" (DfID Sierra Leone, 2011: 5). Moreover, the DfID HW support evaluation also stressed that *"there is little evidence to underpin the theory that increasing healthcare worker salary will eliminate improper charging and increase staff attendance"*, which was the rationale for DfID support to HWs (Stevenson, Kinyeki, & Wheeler, 2012: 12). Additionally, there is no evidence available to support the specific decisions that were made (e.g. regarding the level of salary increase)

Implementation of policies

The documentation analysed shows that important responsibilities for the preparation and implementation of the HRH reforms before the FHCI was given to technical assistants from organisations such as Booz & Co. (later Charlie Goldsmith Associates), Concern Worldwide, the Ministerial Leadership Initiative (MLI), the Office of Tony Blair through the Africa Governance Initiative (AGI), in partnership with the MoHS staff (Heywood, 2010). The high level of *ad hoc* TAs employed highlights the urgency of the reforms, as well as the close involvement of international donors.

Despite the external assistance, the implementation of the HRH reforms was not free of challenges and bottlenecks. Issues during the payroll verification concerned the lack of communication between finance and HRH functions in the MoHS, as well as the little coordination and the overlaps in responsibilities between national and decentralised institutions (Heywood, 2010). Cadres of HWs that were considered key for the implementation of the FHCI were mostly recruited, while others (such as vaccinators, nursing aides, security staff and drivers) were not included in the process, despite playing an important role for service delivery. Consequently, some districts had to identify budgets for the recruitment and motivation of these cadres (Heywood, 2010). Additionally, decisions on the deployment of retired staff have been frequently open to challenges and may not reflect the real needs in terms of geographical allocation (Heywood, 2010).

Finally, a key issue arose when HWs went on strike six weeks before the launch of the FHCI (March 18th to 28th). Strikes for salary increase are not new in Sierra Leone[10], but in this case it occurred at a delicate moment in the preparation of the FHCI and was mainly motivated by the lack of communication to the HWs on the new initiative and in particular with reference to the upcoming salary increase (Krisifoe, 2011).

Financing of policies

A recent evaluation of DfID support to Healthcare Workers Salaries in Sierra Leone (Stevenson et al., 2012) indicates the following breakdown of the respective contributions to the salary payments, made by the GoSL, DfID and GF (table 8)[11]. On average, over the first 3 years, DfID contributed 22% of the costs, the GF approximately 20% and the GoSL the remaining 58%. Overall, DfID committed 10.3 million GBP over a 5 year period to the salary increase. The funding was front loaded as the Government progressively increased its share of the marginal costs (Stevenson et al., 2012).

[10] A strike in 2008 forced the Government of Sierra Leone to raise all employee salaries by 10%, as documented in the Ministry of Finance's 'Salary Grade Table: Effective 1st January 2007 & Effective 1st January 2008' (Kellya & Barrieb, 2010).
[11] Other documents, such as the MoU between GoSL, DfID and GF (GoSL, 2011b) suggest slightly different amounts.

Table 8: breakdown of financial support to salary increase

	2010	2011	2012	3 year total
Total Health Salaries (1)	63,397	76,376	74,783 (2)	214,556
DfID contribution (Le.)	16,071	15,500	15,140	46,711
GF contribution (Le.)	3,342	18,311	21,461	43,114
GOSL contribution (3)	43,984	42,565	38,182	124,731

Notes: (1) Figures are actual expenditure for 2010 and 2011, budgeted amount for 2012. (2) It seems likely that the budget estimate will be substantially exceeded in 2012, as first quarter actual expenditure came in at Le 19,887B. (3) This is not reported, but calculated as a residual in the table

Source: (Stevenson et al., 2012: 20)

Beyond defining the repartition of the financial support to the salary increase, the memorandum of understanding (MoU) between the GoSL (represented by the Ministry of Finance and Economic Development (MoFED)), the GF (through its round 9 principal recipient, the National AIDS Secretariat (NAS)) and DfID also established conditions for the external support (GoSL, 2011b). Among these conditions was the creation of the Health Payroll Steering Committee, which is chaired by the Director of Human Resources of the MoHS, and whose members include representatives from Directorate of Financial Resources (MoHS), HRMO, Accountant General's Office, and the relevant funding agencies (DfID and NAS for the Global Fund). The Health Payroll Steering Committee is responsible for monitoring the payment of salaries and coordinating its management. It also established and monitored the benchmarks and indicators whose fulfilment is linked to the disbursement of the donors' funding (GoSL, 2011b).

DfID also funds most of the technical assistance working with the MoHS, and in particular for the payroll management and attendance monitoring system described below (DfID Sierra Leone, 2011; Stevenson et al., 2012). For these tasks, the HRH Support Unit was created within the HRH Department of the MoHS.

While development partners are largely financing the new salary structure, the GoSL plans to generate or identify other funding sources. However, it is not clear how the GoSL would be able to sustain the increase in expenditure and some analysts question the sustainability of the reforms (Obermann, 2011; Thompson, 2010). Others believe that the salary increase is sustainable by the GoSL in line what was agreed in the MoU (Stevenson et al., 2012). In contrast, they highlight how the element that may raise sustainability issues is the capacity of the HRH Support Unit to continue to manage the payroll and the attendance monitoring system once technical assistance ceases (Stevenson et al., 2012).

Impacts

Data on the results of the payroll clean vary across documents. Some state that 850 phantom HWs were removed (around 12% of the total), while 1000 new HWs were added (Heywood, 2010; Krisifoe, 2011). However, others point out that 1,626 HWs were initially removed but then most of them were reinstalled because they returned to work, were on study leave or provided other satisfactory explanations. Only 297 HWs have been definitively removed from payroll (Stevenson et al., 2012).

The new recruits included mainly those HWs who were previously working 'voluntarily' in the health facilities, remunerated on the basis of the internal facility revenues, but without receiving any

compensation from the MoHS. These HWs were redeployed to the districts where needs were greater, as shown in the table below.

Table 9: redeployment of HWs to the Districts

	Original	Recruits	April Total	% Increase
Bo	703	134	837	19%
Bombali	400	58	458	15%
Bonthe	59	69	128	117%
Headquarters	325	0	325	0%
Kailahun	173	45	218	26%
Kambia	218	13	231	6%
Kenema	489	196	685	40%
Koinadugu	235	10	245	4%
Kono	270	37	307	14%
Moyamba	157	103	260	66%
Port Loko	409	54	463	13%
Pujehun	97	65	162	67%
Tonkolili	291	26	317	9%
Western	2238	45	2283	2%

Source: (Heywood, 2010)

While no information is available on the updated terms and conditions under the revised Scheme of Service, some analyses have been done on the salary increases (Newlands et al., 2011). This shows that the increase was highly skewed towards the higher grades. For example, Grade 14 HWs received a 705% increase, while for grade 3 it was of 314% (Newlands et al., 2011). The table below show the salary increment for some cadres of HWs.

Table 10: Salaries (including allowances) for 3 cadres of HWs (Leones per month)

		Old scales		**New**
Cadre	**Bottom**	**Midpoint**	**Top**	
State enrolled community health nurse	165,626	195,860	226,094	624,000
State registered nurse and staff/community midwife	205,173	245,717.5	286,262	840,000
Medical officer	525,334	667,845	810,356	4,620,000

Source: Booz & Co., 2010 cit. in (Newlands et al., 2011)

The evaluation of the DfID HWs salary support notes that it has not been possible to identify the process undertaken to determine the level of the salary increase. There is no documentation or evidence available to provide such justification (Stevenson et al., 2012). Moreover, the aim of the salary increase was to attract HWs, reward them for the extra work and replace the informal fees that HWs may be tempted to charge. However, some point out that the disproportionately higher increase in the salaries of doctors is not justified by the relative scarcity of this cadre or by their greater workload due to the FHCI. At the same time, other cadres of HWs, such as volunteer vaccinators, were not included in the recruitment and salary increase (Newlands et al., 2011). Some analysts argue that this could have contributed to the fall in immunisation levels observed after the introduction of the FHCI, though other factors may be responsible (Newlands et al., 2011). Concerns about charging informal fees to patients for services and drugs that should be given for free still exist. A public survey revealed that 238 out of 1,168 respondents (approximately 20%) had been asked to pay for officially free services (HFAC & Save the Children, 2011). A civil society organisation, the Health for All Coalition, was later entrusted by the Anti-corruption Commission of Sierra Leone

with the function of guaranteeing an independent oversight on the implementation of the NHSSP and the FHCI (ACC & HFAC, 2012).

The recent evaluation of DfID support to HWs salaries finds that there has been "tremendous improvement" in the quality of the MoHS payroll data management and that there are currently no irregularities in the payroll. Overall, the new management arrangements have eliminated all of the ghost workers from the payroll and increased its reliability and completeness. This led to monetary savings of around $408,200 USD in the period between March 2010 and May 2012 (Stevenson et al., 2012). Additionally, some preliminary data on the impact of the FHCI on the health of the population exists (MoHS, 2011a, 2012d)(Liaqat & Ferry, 2011 cit. in Newlands et al., 2011) and new, more comprehensive evaluations are ongoing, such as the National Perception Survey (NPS) on the Free Health Care Initiative supported by DfID.

However, with reference to HWs' productivity, motivation and incentives, less research has been done. A qualitative study based on the interviews of 9 nurses at Ola During Children's Hospital (ODCH) showed that the FHCI is having mixed effects on the motivation of those nurses. While the salary lift had a positive impact, new challenges, such as increased workload and poor relationships with patients, contributed to the demotivation of the HWs (Lai, 2011). The future research of ReBUILD Project 2 will further contribute to this area of research.

c. Individual performance management systems: Attendance Monitoring System and Staff Sanction Framework, high-level Performance Management Contracts and Individual Performance Appraisal System

Description of policy objectives and approaches

Discussions about the introduction of a Conduct and Sanctions Framework began with the preparation of the FHCI as it was considered one of the pre-launch priority actions (Heywood, 2010). An initial draft of the framework included inputs from the Anti-Corruption Commission, the Medical and Dental Council, the Nursing and Midwifery Board, the Pharmacy Board, as well as the HRH technical sub-group. Despite highlighting the key principles, some major challenges remained and the draft was not ready for implementation by April 2010 (Heywood, 2010). The work continued until mid-2010 when staff absence began being monitored through the Attendance Monitoring System (AMS), and January 2011 when the **Staff Sanction Framework** was implemented (MoHS, 2011b).

The principal aim of the AMS and the Staff Sanction Framework was to reduce absenteeism among HWs. Different monitoring tools to track the HWs' attendance have been developed. PHU staff were trained by district staff on how to use them and report absence. Additionally, spot checks in the PHUs are carried out by the newly created HRH Support Unit. Staff absenteeism reports are provided on a regular basis and are reviewed at Health Payroll Steering Committee meetings (Martineau & Tapera, 2012). The framework envisages a sanction of one month's salary for staff who are absent without authorisation for six days or more in a given month. Verbal warnings are required for staff with three days of unauthorised absence. Additional offences lead to a recommendation for immediate dismissal of the HW (MoHS, 2011b).

Alongside the Sanction Framework, other accountability and performance management systems have been introduced, or are planned: the Performance Management Contracts (PMC) for senior managers (Grade 11-14) and the Individual Performance Appraisal System (IPAS) which will be introduced for staff in Grades 1-10.

As described by Martineau and Tapera (2012), the **Performance Management Contracts** (PMC) were established in 2011 under a wider public sector reform pilot, across seven ministries including the MoHS. The contracts are cascaded from the President to the Ministers, to the Permanent Secretary and finally to Directors. They are not employment contracts, but set a series of yearly targets in a Performance Tracking Table (PTT) which include baseline data and progress indicators for each quarter (see Office of the President, 2011). The progress is analyzed by the Steering Committee on Performance Contracts with representatives from the Chief of Staff, the Cabinet Secretariat, the HRMO, PSRU and the Strategy and Policy Unit (SPU). There is currently no specific reward or sanction attached to achievement of targets.

To complement the PMC system, the public sector reform pilot envisages the establishment of an **Individual Performance Appraisal System** (IPAS) for staff below director level (Grades 1-10). The objective of the system is to "manage and improve performance of the civil service by bringing about a higher level of staff participation in planning, delivery and evaluation of work performance. IPAS […] integrates work planning, target setting, performance reporting and feedback." (cit. in Martineau & Tapera, 2012). A draft tool was presented in March 2012. However, this system is not currently functional.

Drivers of change

The introduction of the AMS and the creation of a Staff Sanction Framework were included in the FHCI priority actions and were one of the conditions indicated for DfID support (GoSL, 2011b; Stevenson et al., 2012), so that an analysis of the drivers of change similar to that of the previous reforms could be made. From the document review, it seems that the main reasons for the delay of this policy was its complexity and the difficulty in reaching an agreement between different bodies, as well as the fact that it was possibly less urgent and conditional upon the implementation of other policies (i.e., payroll cleaning, recruitment and deployment and salary increase).

The documents describing the PMC and the IPAS do not provide any clear information on the discussion relating to the introduction of the two management systems nor on the drivers of change. However, it emerges that these strategies were included in a wider pilot project of public sector reform that involves more than just the health sector. The political will and leadership of the President seems critical for the commencement of and the support to these policies.

Implementation of policies

Beside the initial negotiation to make sure that the Staff Sanction Framework could be organically implemented within the existing legal structure, the approval of the framework did not find extreme opposition, not even from HWs. In fact, according to some analyses, the Acting President of the Sierra Leone Nurses Association appeared to be quite supportive (Martineau & Tapera, 2012).

Analysts agree that once approved, managing the AMS appeared challenging and quite time-consuming both at facility level and the MoHS headquarters. Monitoring by both the DHMTs and the HRH Support Unit can only realistically be done infrequently and spot-checks in remote facilities are rarely taking place (Martineau & Tapera, 2012; Stevenson et al., 2012). However, some suggest that frontline managers appreciate the results (Martineau & Tapera, 2012). The system will need regular review to ensure that staff do not find ways to get around the controls. In the future, with the ongoing decentralization reforms, the responsibility for attendance monitoring should be moved to district level and/or facility level. Involvement of a civil society organisation, the Health for All Coalition (HFAC), in monitoring attendance of HWs has been envisaged since mid-2011 (MoHS,

2011c). Despite the signature of a Memorandum of Understanding between the HFAC and the Anti-Corruption Commission (ACC & HFAC, 2012), it is not clear whether this is being presently implemented.

The implementation of the high-level PMC has been more complex and often delayed. For example, the 2011 contract for Directors at MoHS was signed only in September. This delay was caused by the fact that Directors were cautious about committing to targets without being sure that necessary resources were available. Delays then cascaded from the Minister downwards. Similar issues were experienced in 2012 (Martineau & Tapera, 2012).

Financing of policies

The establishment of a Staff Sanction Framework and its implementation through the monitoring of HWs attendance did not require any important costs. The main expenditure was the human resources involved in the planning and monitoring of the reform, as well as the technical assistance provided to the DHRH. A HRH Support Unit was established within the HRH Directorate to assist with maintaining the integrity of the payroll and supporting the Sanction Framework implementation, with technical support from DfID-funded TA (Martineau & Tapera, 2012).

It is also important to point out that there are economic gains that come with attendance monitoring. The government claims to have saved approximately 240 million Leones (USD 54,000) on their salary bill in 2011 since attendance monitoring and sanctions have been implemented (Charlie Goldsmith Associates, 2012; Martineau & Tapera, 2012).

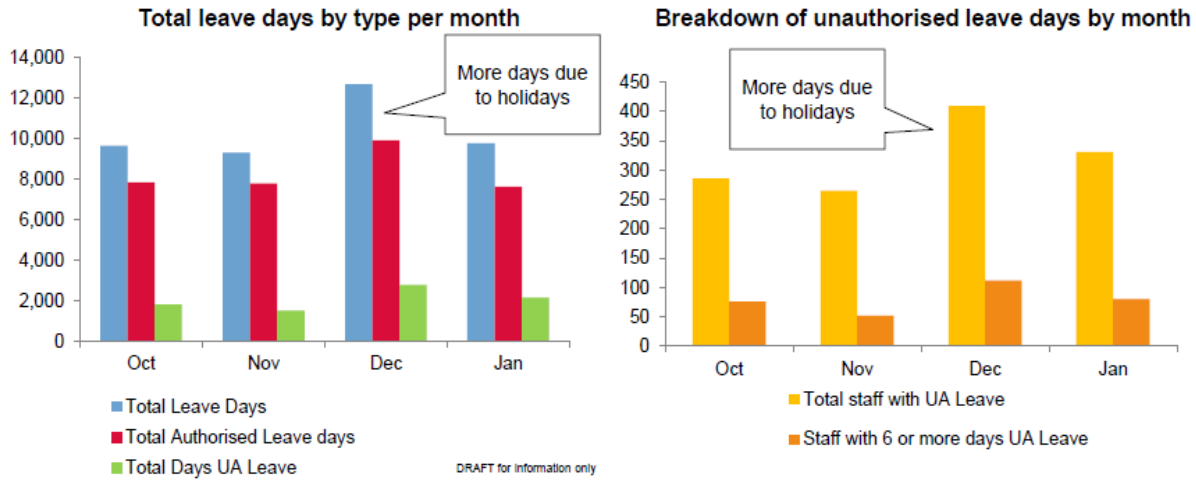
The establishment of PMC and of the IPAS should not entail costs.

Impacts

The Staff Sanction Framework appeared to be working in reducing unauthorised absence. The reported absence levels went down to 5.5% during 2011, according to the Health Payroll Steering Committee, although spot checks suggest it may be actually higher (Martineau & Tapera, 2012). Interviews in the field found that most HWs reported improvements in attendance and it appeared that the message about the risk of sanctions for unauthorised absence being high is well understood by staff (Martineau and Tapera, 2012). During 2011, approximately 600 staff were sanctioned due to unauthorised absences or unknown workstations (Martineau & Tapera, 2012), while 134 were recommended to HRMO for dismissal (Charlie Goldsmith Associates, 2012).

The figures below present the absence days from October 2011 to January 2012 (Charlie Goldsmith Associates, 2012).

Figure 4: Recorded authorised and unauthorised absence days for HWs



Source: (Charlie Goldsmith Associates, 2012)

Additionally, some analysts highlight how the performance management system is still lacking some important parts; job descriptions should be more widely available; induction and orientation processes should introduced; and communication mechanisms between management and staff should be improved (Martineau & Tapera, 2012).

d. Performance-based incentive scheme

Description of policy objectives and approaches

During the launch and the initial implementation of the FHCI, there was a consensus among Ministry officials and donors on the need to provide the health facilities with sufficient materials and financial resources to provide health services efficiently and effectively. Besides efforts to improve and guarantee drug supply, health facilities began receiving additional funding under the "cash-to-facility" scheme. In order to receive this money, facilities had to open bank accounts, which made the introduction of the **Performance Based Financing (PBF) initiative** possible in early 2011 (Martineau & Tapera, 2012). PBF was not entirely new to Sierra Leone as small scale pilot schemes had been set up by NGOs, such as the International Refugee Council (IRC) in Kenema and the Medical Research Centre (MRC). The consensus among donors on the need to better fund facilities, as well as the agreement on PBF as one of the best option to provide such funds, led to the introduction of the "Simple Performance-Based Financing Scheme for Primary Healthcare". The concept paper was presented to the MoHS by the World Bank on February 2010, while the final operational manual was approved in March 2011, shortly before the operational implementation of the scheme on April 1st (Canavan & Coolen, 2010).

As stated in the Operational Manual (GoSL, 2011c), the general objective of the PBF scheme is: "*to change the behaviour of health providers at facility level for them to deliver more quality services under the free health care policy*". The specific objectives of the system are to:

- Provide cash at facility level to cover the local costs of delivering services and removing the need for 'informal' fees.
- Provide financial incentives to facilities in order to increase productivity and quality of care.

- Increase the equity of distribution of resources with funds from PBF allowing facilities to hire contractual workers and finance outreach activities.

In particular, the second objective refers directly to the motivation of HWs. Under the PBF scheme facilities receive a quarterly bonus for their achievements based on a list of output indicators (all core components of the Basic Package of Essential Health Services, plus additional ones relating to management or process indicators e.g. recording staff absence, presence of a functioning Health Management Committee, and avoidance of drug stock outs) that are verified by the District Health Management Teams and the MoHS at central level. This financial bonus is split so that 40% must be reinvested in the facility to improve service delivery and 60% is used to reward all staff, using a points system (Table 11). The scheme encourages team work, rather than individual performance. In some cases, it also contributed to reduce absenteeism as all personnel could agree to reduce the bonus for staff who were frequently absent (Martineau & Tapera, 2012).

Table 11: incentive sharing points

Staff Cadre	Points
CHO	10
Midwife	10
EHO	10
SECHN	9
CHA	9
MCH Aide	8
EDCU Assistant	7
Nursing Aide	5
Laboratory Assistant	3
Non-Technical staff on payroll	2
In-charge bonus	2

Source: (GoSL, 2011b: 39)

Drivers of change

It seems that the PBF scheme represented a logical evolution and improvement of the "cash-to-facilities" system, in order to allocate funds on the basis of measured performance. Such a scheme is also in line with the emphasis given to 'performance' and performance management strategies in Sierra Leone, since and after the introduction of the FHCI. Evidence on the success of PBF schemes both from the pilots in Sierra Leone (Canavan & Coolen, 2010), as well as from other countries in sub-Saharan Africa may also have played a role in the promotion of such strategy.

Unfortunately, among the documents reviewed, no information about the position of the World Bank is available. However, it seems safe to assume that the World Bank played a leading role in the introduction of the PBF scheme, as they provided the TA as well as the funding of the scheme. The World Bank have also supported PBF schemes in other African countries.

More documentation and analysis, in particular from the World Bank, would be essential to better understand the reasons and drivers for the introduction of the PBF scheme. This picture will be completed from Key Informant Interviews.

Financing of policies

It is known that the PBF scheme is funded by the World Bank under the Reproductive and Child Health Project (RCPH) II, until October 2013[12]. However, little information is available on the amount of funding and the financial commitments of the GoSL for the future sustainability of the project.

Implementation of policies and impacts

The PBF scheme was initially implemented in a "simple" form at PHU level, using only existing institutions and administrative arrangements. The fact that the scheme initially excluded all hospitals caused some resentment among staff (Martineau & Tapera, 2012). However, it has now been extended to the 2 hospitals providing maternal and child services, Princess Christian Maternity Hospital (PCMH) and Ola During Children's Hospital (ODCH), and it is envisaged to be rolled out to all hospitals. In a report that considered the first two disbursements to PHUs (April to June and July to September 2011), it found that facilities received bonuses ranging from 200,000 to 2 million Leones. Their calculations in one health facility showed that out of the total earned in one quarter (2,629,000,00 Le), a midwife received 142,720 Le, CHA 113,657 Le, and MCHA 99,450 Le (Martineau & Tapera, 2012).

From the documents available for the review, it is not possible to draw a broader evaluation of the policy, in particular with reference to the effectiveness of the PBF scheme in motivating HWs and improving their performance in terms of quantity and quality of services produced. There is also no information on the mechanisms by which the PBF schemes interact with other existing incentives.

e. Remote allowance

Providing increased remuneration for HWs employed in remote areas to reduce attrition has been on the agenda of the MoHS for a long time(MoHS, n.d.-d). A step in this direction was taken with the definition of different allowances (10% of salary paid as Hard-to-Go Area Allowance), described earlier (par. a).

With the FHCI and the changes in the salary levels and structure it brought, rural incentivisation was discussed again and was included among the priority actions prior to the launch of the FHCI (Heywood, 2010). However, such an allowance was not established during the pre-launch period for a number of reasons:

- The introduction of new salary scales could have changed the motivation for rural posting.
- In some cases, underperforming HWs could prefer remote posting where supervision is weaker.
- Observations from districts showed that non-availability of accommodation is the major disincentive to rural posting and non-salary based incentives could be more effective.
- A draft Civil Service Rules and Regulations that included a proposal for rural incentivisation was under review at the time (Heywood, 2010).

[12] The total amount available for the funding of the RCPH II project is 20,000,000 USD, according to: http://www.worldbank.org/projects/P110535/reproductive-child-health-project-phase-2?lang=en

No official policy documents were retrieved on the functioning mechanisms and the funding of the **Remote Allowance**. However, based on secondary documents (Charlie Goldsmith Associates, n.d.; Stevenson et al., 2012), it seems that a Remote Allowance has been paid to HWs working in rural areas since January 2012 with funding from the Global Fund via the National AIDS Secretariat (NAS). Allowances are calculated as shown in table 12, depending on the remoteness of the facility.

Table 12: calculations for the Remote Allowance

Addition to basic salary	Remoteness level
10%	Western Area Rural and within 10km from regional or district headquarters (HQ)
15%	>10km from regional or district HQ
25%	>10km from regional or district HQ and no car access during the rains
40%	>10km from regional or district HQ and no motorcycle access during the rains

Source:(Stevenson et al., 2012)

Issues arose in the second quarter of 2012 as cash flow shortages meant the NAS was not able to disburse the allowance on time. The allowance was paid towards the end of the year and a new system to ensure its timely pay was put in place with support from TA. However, there is no documentary evidence on the effectiveness of the implementation of this measure.

f. Establishment of the Health Service Commission

Despite the improvement in the payroll management, the evaluation of DfID support to HWs' salaries found significant delays for the new joiners to access the system. Of the 1,474 new employees recruited in March/April 2012, only 8% (124) were on MoHS payroll by June 2012 (Stevenson et al., 2012). The planned creation of a **Health Service Commission** (HSC) should improve this situation.

According to the *HRH Country Profile* and the *HRH Strategic Plan 2012-2016* (AHWO, 2011; MoHS, 2012b), in May 2011, the Government of Sierra Leone announced the formation of the Sierra Leone Health Service Commission, whose functions were *"to appoint the professional staff of Government healthcare facilities and the Ministry of Health and Sanitation and determine the remuneration and other conditions of service of the staff";* as well as to *"set standards for the training of healthcare providers and ensure compliance with the standards; [...]".*

The establishment of the Health Service Commission has been identified by many as an important and urgent reform to ensure the coordination of all matters regarding the training, recruitment, deployment, motivation, accountability, supervision and sanction of HWs (Heywood, 2010; Martineau & Tapera, 2012). There is little information available on the current functioning of the HSC. It seems that members have been appointed and met on a few occasions but the Commission has no secretariat support, nor recurrent budget. Moreover, some analysts cast some doubts on the real powers and tasks of the HSC, especially on how it interacts with existing bodies such as PSC and the HRMO (Stevenson et al., 2012).

g. Human Resources Information System

As reported in the *HRH Country Profile* (AHWO, 2011), there is currently no functional relationship between data collected for the Heath Information System (HIS) and data collected on HRH. HRH data collection is done manually and relies on physical transfer of records, while the HIS is computerised and information transmission is electronic from the hospital-level upwards. It was clear that the DHRH needs a computer-based system to keep track of all HWs, including regularly updating the payroll. In 2011, the MoHS requested WHO to support the establishment of a **Human Resources Information System** (HRIS).

A HRIS situational analysis took place in April 2011 (Phiri & Ahmat, 2011), to assess the current system of data collection, management and reporting and to propose next steps for the establishment of a HRIS or iHRIS. However, despite being managed by the same unit within the HRH Directorate, the current payroll and AMS system and the HRIS being developed, are not yet integrated (Stevenson et al., 2012).

4. Lessons and conclusions

How policies developed

Figure 5 plots a timeline of the main official policies and the most important shifts in HRH issues in Sierra Leone since 2002. It helps understand the sequencing of the changes over time and how the policies fed into each other in their development. Alongside the analysis carried out in previous sections, the graph highlights the different phases in HRH policy making.

During the initial post-conflict period (2002-2009), HRH issues were considered critical for improved function of the health system: challenges were correctly identified and solutions proposed (cf. Sandi, n.d., 2007). However, the suggested reforms were rarely implemented and the response to the challenges remained fragmented. This may have been attributable to the 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).

In 2008, the second *Sierra Leone Poverty Reduction Strategy Paper 2008-2012* (GoSL, 2008) was launched. It identified the reduction of maternal and child mortality as one of the priorities of the country. This influenced the development of the *National Health Sector Strategic Plan 2010-2015* (MoHS, 2009), the introduction of a *Basic Package of Essential Health Services* (MoHS, 2010), and the launch of the Free Health Care Initiative (GoSL, 2009). The sequencing of these policy documents highlights the extremely high priority given to the attainment of this objective. The President of the Republic was directly involved in the launch of the initiative, which was considered one of the Presidential Flagship Projects, by the relevance given to it during his political speeches (Awareness Times, 2011), as well as by the work done by the Strategy and Policy Unit (Scharff, 2012). The launch of the FHCI garnered strong political support and a brief preparation period (November 2009 to April 2010) was allowed to plan for the implementation of the initiative. This made Sierra Leone one of the few (if not only) countries to tackle these key problems and to explicitly address the link between the removal of fees for targeted groups and the income and incentives faced by HWs (Newlands et al., 2011).

It is in this context that the most important recent reforms with respect to HRH in Sierra Leone took place. As one can infer from the graph, the announcement of the FHCI, its urgency and the political pressure that it created to deliver results, acted as a catalyst to realize the critical HRH reforms that had been proposed for many years, but never realised. This catalytic role of the FHCI is confirmed by a quote from a key informant (consultant) in Krisifoe (2011: 37):

> *"What was amazing about the free health care is that everyone came together. It was the first time I had seen this. The Ministry, the donors, the NGOs all came together [...]"*.

After the momentum created by the launch of the FHCI, it seems that the reforms are slowing down and the implementation of many has been delayed (one important example is the operationalisation of the HSC). The graph also shows in 2011-2012 a disconnection between official policies and strategies and operational shifts, as the HRH policies approved in 2012 followed operational reforms as if making them official and organic without proposing new arrangements.

From the documents available, it is difficult to assess the precise role that each international partner played as a 'driver of change'. In general, their support to the FHCI clearly contributed to making this reform a catalyst for other critical changes in all areas of the health sector. As aid constituted 78% of

total public health spending in 2007 (OMP (2008) Public Expenditure Review of the Health Sector in Sierra Leone, cit. in Canavan, Rothmann, & Coolen, 2009), it is safe to assume that donors played a major role in supporting this initiative, as well as all other reforms that followed, both by providing TA and funding for such policies. The level of sustainability of the policies, given the high external support, remains uncertain.

Effectiveness of policies to date

The little information existing on the effectiveness of the policies has been reviewed in each section. In general, official and operational policy changes on HRH issues are so recent that a systematic review of their effectiveness has not been carried out. There is no evidence on the overall effect of these shifts on training, motivating, attracting and retaining the public health workforce in Sierra Leone. The research of ReBUILD Project 2 should be able to contribute to this analysis, broadly at the incentive environment set up for the HWs by these policies, and how effective it is to address HRH issues.

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

The HRH policy trajectory in Sierra Leone shows the importance of a catalyst initiative to overcome political uncertainty (both with respect to internal and external support), build a momentum and create wide support for radical reform of the health sector.

The question of whether this policy-making 'pattern', from political uncertainty and lack of coordination to a catalyst reform enjoying political and financial support to other corollary reforms, could be described as typical or characteristic of a post-conflict context remains unclear.

Obviously, the state of the health system after the war was so dire to require radical reforms in its organization, including for HRH, for whom challenges were appalling. It could be hypothesized that in other contexts, where the situation is not so critical, such reforms could be perhaps postponed or diluted over time, while in a reconstruction context, the gravity of the situation, accompanied by the general climate of reform, renovation and change[13] could foster new initiatives. In this sense, it is important to point out how the shifts implemented in the 2002-2009 period should not be underestimated, although carried out with less public attention and without the political and financial support (both internal and international) that the post-2009 reforms enjoyed. These early reforms would require further exploration, both by gathering new documents and through interviews. However, these reforms were certainly slower and less effective than those pushed by the launch of FHCI.

In explaining the process of implementation of the reforms, one conflict-related issue that emerged was the lack of capacity within the central institutions for the planning and effective implementation of reforms, which is a central theme in the post-conflict literature (Witter, 2012). In 2008, the governmental capacity was low and this slowed progress in the reform agenda (Scharff, 2012). This could account for the slow or non-implementation of reforms in the 2002-2009 period, and is also reflected in the high dependence on TA that the planning and implementation of the post-2009 reforms required.

Although it should be confirmed by further analysis, it is possible that the post-conflict situation and the perceived need for radical, urgent changes (after some years of stalemate) allowed the revision

[13] The title of the 2008 PRSP, "An Agenda for Change", clearly signifies this general climate in Sierra Leone.

of power relations and dynamics between influential actors that would have been impossible without such disconnection from the past. Examples of this are in the establishment and the role of the SPU, which was external to the Ministries but succeeded in collaborating with them, dictating their agenda and ensuring coordination; the acceptance of high level international TA; as well as the support to performance and sanction mechanisms, such as the Staff Sanction Framework, by representatives of the health workforce.

Another theme that seems characteristic of post-conflict contexts is the focus on 'performance'. Some have noted that many early PBF schemes have been introduced in post-conflict countries (Toonen, Canavan, Vergeer, & Elovainio, 2009). Although the reasons are unclear, it has been suggested that this could be due to less inertia in the system, loss of HWs intrinsic motivation so that they are amenable to financial incentives, weakness in control mechanisms that need to be replaced, break down of central funding, etc. (Witter, 2012). In Sierra Leone, the concept of 'performance' is not limited to the PBF scheme for PHUs, but has also been earlier introduced outside of the health sector for the high-level management contracts (PMC). The reasons for such focus on 'performance' should be explored further, to verify what has been hypothesised for other countries and reflect on the link between post-conflict context and 'performance'.

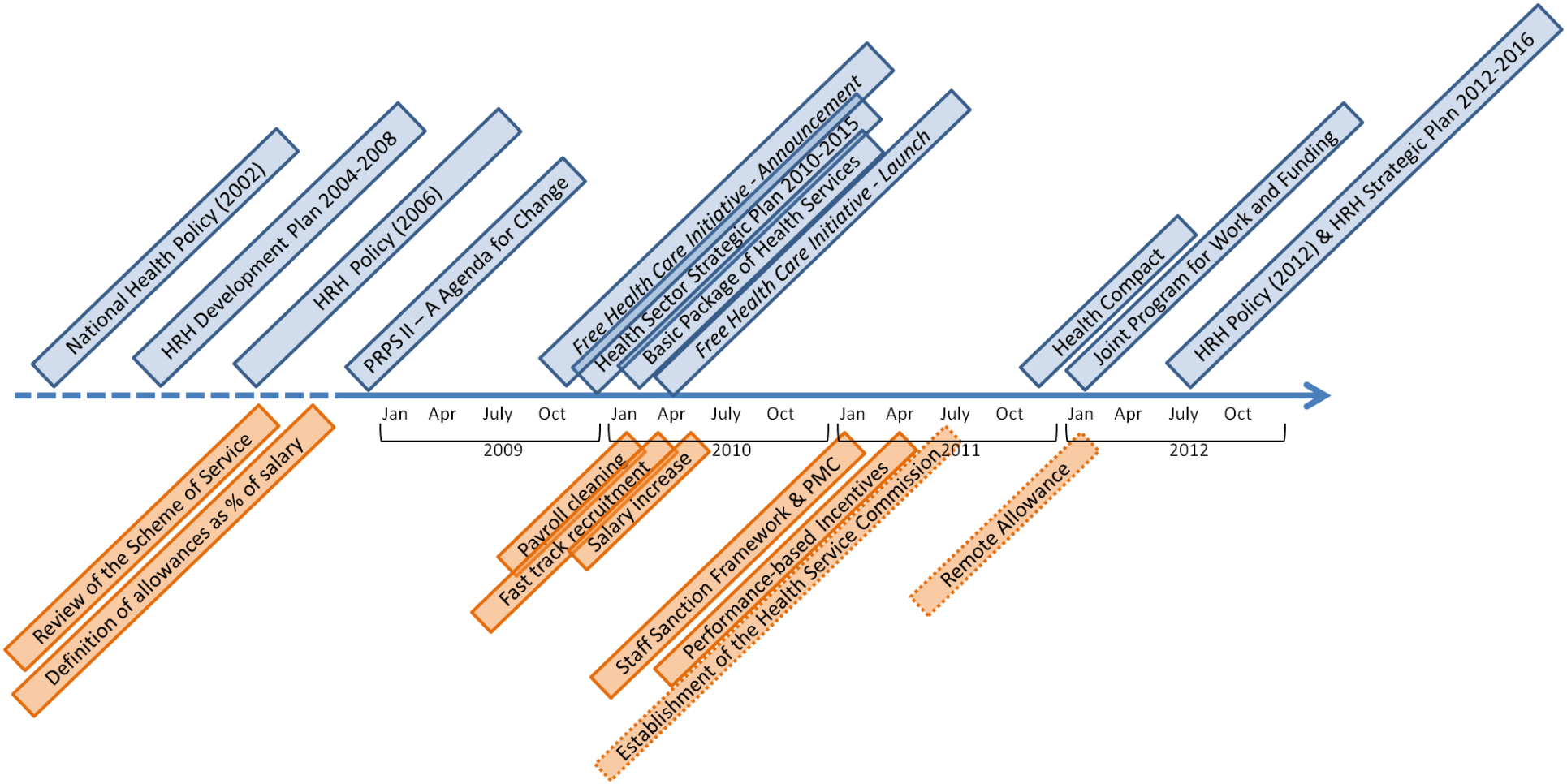
The analysis of these issues, through further document review, key informants interviews and comparison with other countries should shed more light on the conflict legacy and the post-conflict decision-making and reform processes.

The apparent success of Sierra Leone in addressing some of the HRH issues cannot hide two facts:
(i)one-off exercises were preferred to more structural and sustainable reforms e.g. the fast-track recruitment process was preferred to the creation of the HSC. As Stevenson et al. (2012) highlight, most of the systems developed to support HWs' salaries and improve attendance are 'stop-gap' measures. Their effectiveness may not be questioned, but their sustainability raises some concerns, especially once the external technical assistance support terminates.
(ii) only the most urgent, short-term issues were tackled (albeit admittedly very important ones), while others requiring more long-term solutions, e.g. pre-service training of new HWs, seemed to be left for later on. Since 2011, the World Bank through the RCHP II grant has provided support to the Health Training Institutions (specifically, COMAHS and the School of Community Health Sciences), to strengthen and improve on the quality of their graduates and the numbers graduating each year. MoHS and partners should not forget these issues, while they continue to monitor, evaluate and improve the reforms already implemented.

In the future, the main challenge for Sierra Leone would be to maintain the support, political and financial, around health policies and reforms, as attention and pressure around the success of the FCHI will decrease. Existing policies will need to be evaluated and adapted accordingly, and new ones implemented.

More research is needed to better understand the exact balance and the dynamics between the external and internal drive of the reform process, as well as the role of other less prominent but important stakeholders, such as the professional boards, the private sector, the implementing partners and NGO etc. in the definition of the reform agenda. It will be also important to investigate the effects of the different reforms on the motivation of HWs, and analyse how the interplay between the different financial and non-financial incentive and management mechanisms affects the performance and satisfaction of HWs and contributes to addressing the HRH challenges of the country. ReBUILD Project 2 should be able to contribute to this research agenda.

Figure 5: the sequencing of the official HRH policies and the operational shifts and changes



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6. Annexes

Annex 1: List of all documents retrieved

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Annex 2: Data on HW availability

Table 1: Health staff* and gaps, by cadre, in Sierra Leone: 1991-2009

Cadre	1991	2003	2009	Total posts	Gap 2009	% posts filled
Medical Officers	207	71	75	534	459	14%
Paediatricians	16	4	1	54	53	2%
Midwives	132	111	95	300	205	32%
Dentists	15	6	5	52	47	10%
Psychiatrists	1	1	1	8	7	13%
Obs/gynaecologists	23	6	5	54	49	9%
MCH Aides	0	530	825	2000	1,175	41%
Public Health Sp.	33	18	24	30	6	80%
SR Nurses	625	266	685	1386	701	49%
Surgeons	13	7	5	54	49	9%
Pharmacists	23	13	17	30	13	57%
Sp. Physicians	17	6	3	10	7	30%
Total	1,105	1,039	1,741	4,511	2,771	39%

* including public and private HWs
Source: Framework Document, 2009 cit. in (Newlands et al., 2011)

Table 2: Stock of Medical Personnel in MoHS for 2006/2007

- **CADRE……2006……..2007…....VAC.....GAP**
- Med.Officers (G.Ps)……88……..64……..300……..236.
- Paed……3……5……17……12.
- Dentists……8……8……20……12.
- Obs/Gyn……7……7……15……..8.
- Pub.H.Spec……22……21…...…30……9.
- Surg. Spec……..8……..8……...30……...22.
- Physi. Spec…..5……...7……...30……...23.
- Psych……...1……...1……..7……6.
- Haemat……...1……...1……..…8……7.
- Midwives……..57……87……..200……..113.
- Clinical Nurses (RN,NS,WS/O)…….202……..225……..600…....375.
- N/Anaesth……..11……11……...70……59.
- MCHAides……..…980…....1,228……..1,500……..272.
- Pharmacists……14……17……30……...13.
- Pharm. Tech……..120……..130……300……170.

Source: (Sandi, 2007)

Annex 3: concentration curves and indices for HWs in public, NGO/FBO and private sector (2007)

Source: (Newlands et al., 2011) based on MoHS data.

Figure 1: Concentration curves for Government, NGO and Private HWs (2007)

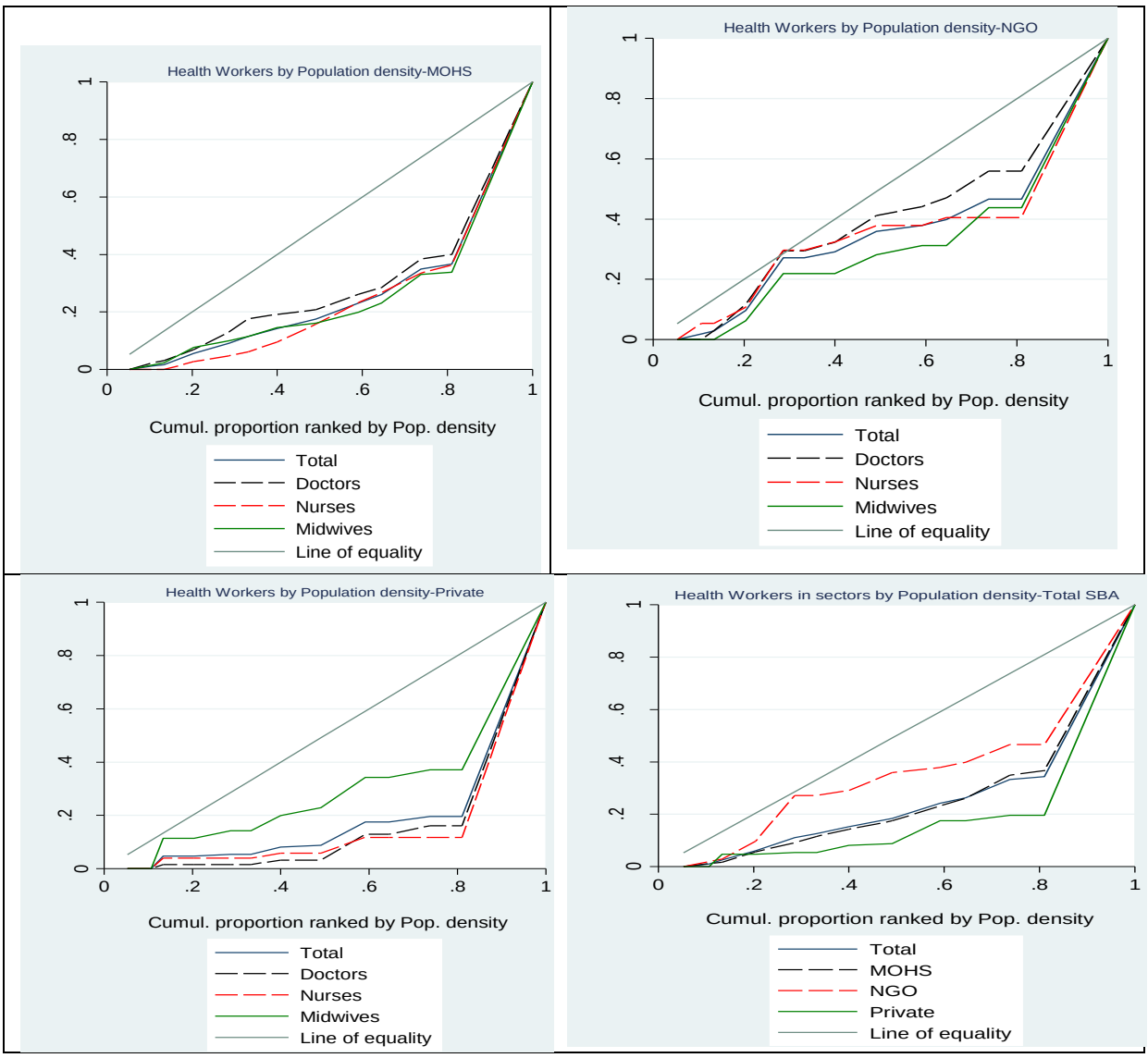

Figure 2: Concentration Indices for HWs (2007)