Health worker incentives: stakeholder mapping report (Sierra Leone)

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Abbreviations

RPC.....ReBUILD Programme Consortium

USL.....University of Sierra Leone

COMAHS.....College of Medicine and Allied Health Sciences

HRMO.....Human Resource Management Office

HRH.....Human Resource for Health

PSC.....Public Service Commission

CMO..... Chief Medical Officer

CNO..... Chief Nursing Officer

DMO..... District Medical Officer

HSC.....Health Service Commission

WHO.....World Health Organisation

DFiD.....Department of Foreign and International Development

JICA..... Japan International Cooperation Association

UNICEF.....United Nations Children's Fund

UNFPA.....United Nations Population Fund

ADB.....African Development Bank

CHASL .....Christian Health Association of Sierra Leone

MRC.....Medical Research Council

NASSIT.....National Social Security Trust

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Introduction

ReBUILD is a six year research project funded by the UK Department for International Development. It aims to understand how to strengthen policy and practice related to health financing and how different health financing strategies affect the poorest households. It also seeks to understand how different innovations in human resource management and opportunities for reallocating roles among health professionals can lead to improved access to health care.

The ReBUILD research programme is focusing on health system development in post-conflict countries, to develop lessons for governments on how to make or recreate and sustain fair health systems. Countries of study include Sierra Leone, Uganda, Cambodia and Zimbabwe

During the inception phase in 2011, the ReBUILD team in Sierra Leone conducted a situational analysis to assist with the prioritization of research questions. This led to proposals for research being developed on three main areas: (1) Health Financing i.e. care and consequences of health care charges for poor households, (2) Health Workers Incentives and (3) Decentralization and Contracting . These studies are being conducted by the ReBUILD Team based at COMAHS, with support from Queen Margaret University in Edinburgh and the Liverpool School of Tropical Medicine.

The main goal of the Health Workers project is to understand the post-conflict dynamics for these workers – and ultimately how to reach and maintain incentive environments for them to support access to affordable, appropriate and equitable health services. The first research tool used within this project has been stakeholder mapping, which is the focus of this report.

Research methods

Objectives

The overall objective of the **stakeholder mapping** better is to understand the key actors who have influenced policy and practices in human resources for health in Sierra Leone over the post-conflict period. This has three purposes:

1. To contribute to our understanding of the drivers of HR policy and practice over the period of 2000-2012 (and perceptions of these drivers by key players)
2. To identify individuals to contact with whom to conduct more in-depth interviews as part of the research process
3. To help ReBUILD to target research messages effectively when findings are available

Participants

The stakeholder mapping took place in Freetown on the 11th October 2012. Participants were selected for invitation based on an initial brain-storming of the research team. They included key individuals within the Ministry of Health and Sanitation (MoHS), regulatory bodies, public autonomous bodies involved in the human resource field, training institutions, development partners, NGOs and district medical officers etc. The meeting focused on national level participants as this is believed to be the main locus for decision-making on human resources policies. A list of the posts of those who participated on the day can be found in annex 1.

Research process

A set of questions were prepared to guide the discussion (see annex 2). These questions were structured as follows:

- Identifying current actors in relation to HR policy and practice in Sierra Leone
- Probing their roles and inter-relationships
- Understanding the changes in these over the period since 2000
- Plotting the actors according to their perceived influence and interest in this field

These questions were used to guide a group discussion, with the aim of revealing consensus and different perspectives on issues.

Research limitations

Two main limitations were noted.

1. The day of the stakeholder mapping coincided in a political rally, organized after invitations had been issued. Consequently, the session was relatively brief (3 ½ hours), which limited the extent to which some topics could be probed. In particular, roles and inter-relations were described fairly sketchily. Mapping of actors in 2002, after the war, was also not attempted for reasons of shortage of time.

2. The participants who attended provided a strong representation of Ministry officials, public bodies and regulatory agencies. However, development partners (donors and NGOs) were absent or poorly represented. This has to be borne in mind when reading the findings.

Findings

Who are the actors now?

A list of key actors in relation to HRH policy and practice in Sierra Leone were brainstormed by the group as a whole. They are presented by category below. Actors were conceived as positions or organizations, rather than individuals.

Within the MoHS:

- Permanent Secretary
- Chief Medical Officer
- Chief Nursing Officer
- Directorate of Planning
- Director of HR
- Director of Training
- Training coordinator
- Director of Financial Resources

Other Ministries and public bodies:

- Health Service Commission
- HRMO
- Ministry of Labour
- Ministry of Finance
- Ministry of Education
- NASSIT

Political bodies:

- Parliamentary Committee for Health
- Minister's Office
- President
- Local councils

Regulatory bodies:

- Chair of Medical and Dental Council
- Nurses & Midwives Board
- Pharmacy Board

Training institutions:

- The University of Sierra Leone
- COMAHS
- Midwifery training schools

Donors:

- WHO
- DFiD
- Global Fund
- JICA
- UNICEF
- UNFPA
- ADB
- World Bank
- EU
-

NGOs:

- Local NGOs such as MRC
- International NGOs such as Save the Children
- Umbrella grouping and coalitions, such as the Health Coalition and Health Alert

Private sector:

- Limited representation for private for profit sector
- CHASS represents the mission sector

Discussion of role of actors

Ministry and public bodies

Within the MoHS, there has been a shift of power, as some perceive it, from the 'technician' (headed by the Chief Medical Officer - CMO) to the 'administrators' (headed by the Permanent Secretary - PS). The roles within the MoHS are apparent from their titles but are rated variably, in terms of interest and influence (see below).

The Human Resource Management Office (HRMO) – this used to be called 'The Establishment Office' – is the employer of all public sector workers. It acts as a clearing house for the Public Services Commission (PSC). It deals with the higher level staff (grades 7-14). Grades 1-6 are handled by PSC. Many of its functions (for health personnel) will be

delegated to the recently established Health Service Commission (HSC), whose role is not entirely clear at this moment. It will be linked to the Ministry but will be independent. It should take over responsibility for all professionals.

The regulatory bodies maintain lists of registered practitioners. There is currently a gap for CHOs. There is discussion of creating a body to regulate all health professionals, to avoid the multitude of potential regulatory bodies.

The Ministry of Labour (MoL) – consults with the Employers' Federation and the Labour Congress (Health Workers' union) in a tripartite arrangement.

The National Social Security Insurance Trust (NASSIT) currently collect contributions from health staff (5% of basic salary; 10% from employer) for pensions (lump sum and pension) and death-in- service & invalidity benefits. All civil servants have to join and there are also private voluntary contributors (e.g. health NGOs). In the future, it is planned that NASSIT will have a role in developing social health insurance in Sierra Leone (SLASHI).

Development partners

As the group did not include any donors, the perspectives on donor roles were quite limited. Two main donors are supporting salaries for HWs (DFID and the Global Fund). WHO funds training and also provides technical support. A large number focus on training, including UNICEF, UNFPA, the ADB, and JICA. The World Bank is supporting Performance Based Financing (PBF). The EU provides support via WHO.

Non-Governmental Organizations (NGOs) were reported to be very instrumental in the development of the three main documents which currently frame HRH issues (the HR policy; strategic plan; and performance based financing). The contributions of the NGOs in the health partners working group was noted. In addition, NGOs and coalitions of NGOs are now playing an important role as the 'eyes and ears' of the government on the ground – monitoring staff attendance in facilities, for example, or whether staff have taken up postings. The HR Directorate trains them in monitoring, though this is not entirely uncontroversial – some group members felt that M&E should be done by the MoHS, not by outside organizations.

After the war, NGOs paid higher salaries and attracted staff from the public sector. However, some then left or their funding declined and the government had to re-employ the staff they left. This was seen as unsatisfactory, so staff in NGO-supported centres now remain in public employment, with NGOs paying top-ups.

Political bodies

HR was meant to be devolved to the local councils from 2004 but this has not yet taken place fully. Similarly, they are meant to be responsible for monitoring but are not yet active. Staff are employed and paid centrally. They are also promoted centrally so that it is hard for councils to monitor their performance. There is no power as yet to dismiss them etc.

Some advocate local hiring and training as an effective way of improving retention. This is now being done for nurses (SECHNs). The interest of the local councils are variable – some districts (like Western) were reported to be engaged, but other districts not.

For PBF, the councils are meant to do quarterly monitoring and HR attendance is a cross-cutting indicator, so there is some role for councils in relation to that now, though it may not be that effective yet.

In relation to national political bodies, the President and Minister are obviously influential. The Parliamentary Committee for Health takes decisions on Acts, such as setting up the HSC. It can cross question the CMO or other officials. It was not however accorded a high score for influence in the exercise (see below).

Private & mission sector

Half of the nurses who work in the public sector are also working in the private sector. However, the private sector is not well organized or represented. Private HWs fall under the regulatory bodies as they have to have registered to open a clinic. However, there are many unauthorized clinics. Moreover, information is lacking on the private sector – even basic information such as their number, how they are funded and what quality of care they provide.

When public salaries were very low, staff flowed into the private sector. But as soon as the pay rose, they drifted back. Some work in private sector due to the delays of recruitment into the public sector.

The Christian Health Association of Sierra Leone (CHASS) represents the mission sector. Mission hospitals are often in underserved areas, and many have public sector staff who have been seconded there. On the whole, they have lost their overseas subventions and so are more in need of government support.

Comparing with the post-war situation

'After the war it was complete chaos. The NGOs came and went to difficult areas. They employed the nurses directly, without even consulting the Ministry. There was not even an HR directorate in place in the Ministry. Some of them identified where they wanted to go, without consulting the Ministry. They never presented any budget. But this was a war. We had to bend backwards in the Ministry. But after the war, these problems came up – the nurses lost their jobs. The capacity of government to absorb them then was nil. But with time, we managed'.

In those days there was only a manager of HR, under Planning and Information. (The Director of HR was only appointed in 2010.) However, these other posts were in place – the CMO, PS, CNO. The regulatory bodies were also in place – these government outfits remained from before the war, but with less capacity. The structures were similar to now but the processes different.

There are more checks and balances now, e.g. the regulatory bodies are able to vet people coming in to work, whereas during the war, some NGOs brought in unqualified staff.

After the war, recruitment and training were very haphazard. There was temporary training to fill the gaps – many were taken on after very short trainings. The Ministry of Health was doing most of the training then, but over time the Ministry of Education (MoE) has taken on this role (since 2005). The School of MCH Aides and Midwifery is under the MoHS but all others are under the MoE. This is difficult for students, as they used to get stipends and now pay fees.

Decentralisation has been another big change - the District Councils were created in 2004.

Some feel that there have also been changes to postings. Before the war, staff were transferred to rural areas routinely which was criteria for promotion but that has faded

away. It used to be more disciplined. There is also, according to some, more political interference now.

'When you transfer someone, politicians come and stop you (MPs, Ministers etc). The CMO can't do his job well. Transfer is not a form of victimisation – it is part of your conditions of service'.

There has also been a change in cadres – e.g. the replacement of TBAs (before the war) with MCH Aides. Some feel that there has also been a change in quality of personnel – that task shifting is watering down the quality of the staff in posts.

During the war, staff charged fees for service. Now there are no or low fees for service, which undermines staff desire to go to remote areas. But now there is a remote area allowance, which is relatively recent.

How have donors changed? NGOs and donors like GAVI used to pay salaries direct to staff in districts. They also offered better working conditions. Others, like the Bank, employed staff in project management implementing units but opposed top-ups to public sector staff.

After the war, there was no formalised contribution to the MoHS by donors. Now, since 2011, there is a Compact (linked to IHP+) and in general there is more coordination, including a Joint Programme of Work and Funding (JPWF) and a move towards basket funding. This shift is mostly beneficial but has adverse effects too – e.g. supplies and logistics were more timely when donors supplied direct. However, there used to be wastage as some districts were double-supported by donors. But now with the JPWF, the Ministry makes sure that allocation to districts is more rational. This has been a gradual process – it has taken ten years.

At the council level, there is now one council health plan, which links all of the previous disparate NGO plans. This is aggregated up to national level as well. The National Health Sector Strategic Plan which launched in 2008 was part of the shift towards greater harmonisation. There is now a better plan for HR – 'we know who we need and where'.

Civil society has also seen great changes – it hardly existed after the war.

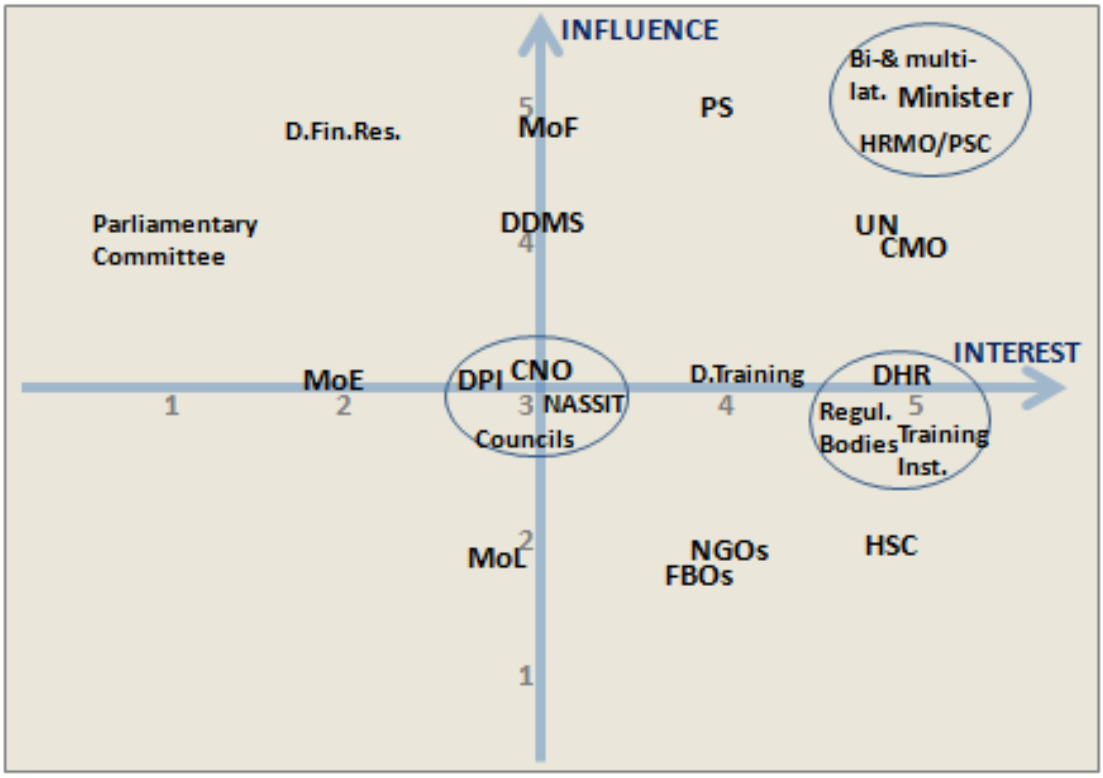
How influential and interested are current actors?

The placing of the different actors is shown in Figure 1. (Scores range from low at 1 to high at 5.) Participants agreed to score according to ACTUAL influence and interest – not according to the level of influence or interest which the actors ought to have in principle. For example, the PS is responsible for all things affecting HR, and so should be interested, but was seen as having too many commitments (and was therefore accorded an interest score of 4). Conversely, some felt that the CMO is the most important person for HRH – the lead technical person. But his influence is undermined now and he is overruled, leading to an influence of 4, but interest of 5. The CNO was seen to be in a similar position – previously powerful but now less so

In the top right quadrant (those with greatest influence and interest) were placed the donors, the Minister (the President was not ranked as this was considered too political), and the HRMO/PSC (all with scores of 5, 5).

The most extreme example in the top left (high influence, low interest quadrant) was the Parliamentary Committee, with a lowly 1 for interest, though its influence was assessed at 4.

Figure 1 Plotting actors for influence and interest



Despite the recognition of their contribution mentioned above, the score given to NGOs as a group for influence was relatively low, suggesting that their role may be changing now that Sierra Leone is moving out of its post-conflict phase. They and the FBOs are grouped into the bottom right quadrant (high interest, low influence).

The regulatory councils and training institutions were also regarded as interested but relatively lacking in influence.

For the local councils, there were very divergent views on their influence and interest. Some were seen as very interested (e.g. Western and Bo) but others not.

As all actors were selected for playing some kind of role in relation to HRH, it is perhaps unsurprising that none are situated in the middle of the bottom left quadrant (low influence and low interest).

Conclusion

This exercise was just a preliminary step in identifying and defining the role of some of the key actors in human resources policy and practice in Sierra Leone. Due to time limitations and the absence of some key constituencies, the probing of roles and inter-relationships was relatively superficial. However, the process will be deepened through other tools, including document review and key informant interviews. This first stage has provided insights into some of the players, some of the changes which have occurred, and some of the perceptions of dynamics between players.

Annex 1. List of participants

No.	Name	Designation
1.	Dr. Heidi Jalloh-Vos	HPM- MRC
2.	Dr. Mohamed Bawoh	Lecturer, COMAHS
3.	Moinina Momoh	Admin. Officer, MoHS
4.	Abdul Karim Conteh	MLSS
5.	Dr. Arthur C. Williams	Medical and Dental Council SL
6.	Amanatu Kamara	NASSIT
7.	Emile Koroma	HR Manager, MoHS
8.	Elizabeth Lemor	Principal PHS
9.	Prince E O Cole	Director of HR, MoHS
10.	Winston Webber	Ag. Deputy Registrar, COMAHS
11.	S S Alie-Korosa	Chief Education Officer, MEST
12.	Sr. Christiana Massally	Sr. Public Health Sister
13.	W. Johnson	PBSL
14.	Sophie Witter	ReBUILD UK Project 2 Lead
15.	Maria Bertone	ReBUILD UK
16.	Dr. Joseph Edem-Hotah	ReBUILD PI, SL
17.	Dr. Mohamed Samai	ReBUILD deputy PI, SL
18.	Amara B. Katta	ReBUILD Administrator
19.	Rogers Amara	ReBUILD Quantitative Research Officer
20.	Yusuf Jimmy	ReBUILD Qualitative Research Officer
21.	Yatta Jennifer Kosia	ReBUILD Uptake Communications Officer
22.	Alfred Samai	COMAHS
23.	Nabieu Yambasu	COMAHS

Annex 2. Questions for stakeholder mapping exercise, ReBUILD Sierra Leone, health worker incentives research project

Introduction

The ReBUILD research programme is focussing on health system development post-conflict, to develop lessons for governments on how to create and sustain fair health systems.

One of the research projects in Sierra Leone focuses on understanding health worker incentives to inform policies on recruitment, retention, distribution and management of health workers.

The objective of the stakeholder mapping is to understand better the key actors who have influenced policy and practices in HRH in Sierra Leone over the post-conflict period. This will help us to identify individuals for more in-depth interviews. It will also help us to target research messages.

To do this, we would appreciate your frank views and brainstorming.

There are no right or wrong answers, and the group may or may not agree on how different groups were positioned. The main thing is to share our views and to see whether or not there is a consensus.

Questions

1. Who are the main stakeholders involved in the process of developing policies and practice for human resources for health in Sierra Leone now?

Probes:

a. Internal and external

b. Influential individuals and organisations

c. Consider different groups such as government players, development partners, NGOs, outside experts, regional bodies etc.

2. What kinds of roles do they play?

Probes:

a. What is their focus of work and interest?

b. How much influence do they have?
c. How is this shown?
d. What sorts of issues do they influence?
e. How do these actors relate to one another?
f. Are there any particular groups or networks through which they meet or work?

3. Thinking back to 2002, after the war, if you were present at that time, who do you think were the main actors involved in the process of developing policies and practice for human resources for health in Sierra Leone?

Probes:
a. Internal and external
b. Influential individuals and organisations
c. Consider different groups such as government players, development partners, NGOs, outside experts, regional bodies etc.

4. What role do you consider each main actor played?

Probes:
a. What was their focus of work and interest?
b. How much influence did they have?
c. How was this shown?
d. What sorts of issues did they influence?
e. How did these actors relate to one another?

5. Describe how this has changed or not over the post-war period

Probes:
a. If something has changed, why was that?
b. Where there any particular phases/events/times/turning points during this time?
c. If so, can you describe them?

6. If you had to place these individuals or organisations on two axes of influence over HRH and interest in HRH, where would you place them?
Probes:
a. In 2002, at the end of the conflict
b. Now, in 2012