Incentives to improve health workers' retention and motivation: implementation challenges and informal practices at district level. The role of DHMTs and NGOs

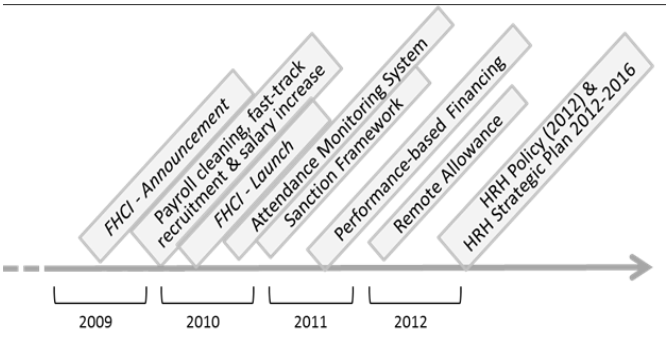
Policy Brief

Background

With only 0.071 doctors and 0.631 nurses per 1,000 population working in public employment, Sierra Leone suffers from extreme shortages in the health workforce and faces enormous challenges relating to filling essential positions, ensuring an even distribution of staff across the districts including rural and remote areas, decreasing absenteeism, and reducing attrition[1]. Human resources for health (HRH) challenges hamper the good functioning of the health system and reduce the potential for improvement in health outcomes.

With the launch of the Free Health Care Initiative (FCHI) in 2010, a series of **HRH-related policies and reforms** were designed and approved to address some of the challenges (**Figure 1**)[2].

Figure 1: HRH-related policies and reforms, 2009-2012



Additionally, most donors (such as the Global Fund and the World Bank) and some NGOs eliminated the extra payments that they were providing to health workers, sometimes in relation with disease-specific activities (e.g. HIV services).

Overall, the introduction of such HRH policies and reforms showed the will and the efforts of the Ministry of Health and Sanitation (MoHS) and its partners to create a **harmonized and aligned incentive package for health workers**. These efforts were partially successful in improving recruitment, retention and motivation of health workers, at least at the initial, design stage[3].

In this study, we look beyond the design of HRH policies in the post-conflict period, to **analyze the actual implementation of the HRH policies at local level** and reflect on the challenges of translating knowledge not only into policy but also into effective practice.

Research questions

** What are the implementation challenges for HRH policies and reforms?*
** What happens in practice in the districts when District Health Management Teams (DHMTs) and NGOs work side by side to support (or not) these policies?*
** What are the consequences of the HRH policies and the local practices on the incomes of health workers?*
** What lessons can we learn for the current context after the Ebola Virus Disease (EVD) outbreak?*

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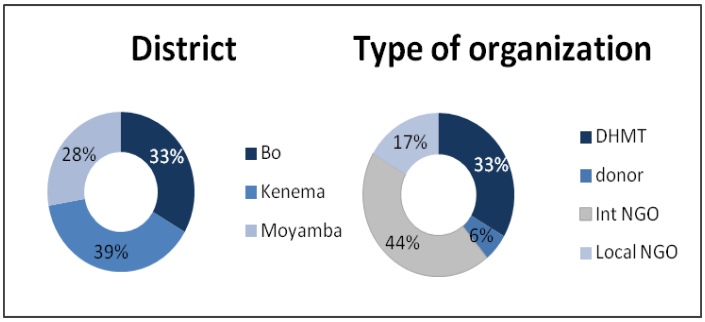
Methods

The study was carried out in September-December 2013 in the districts of **Bo, Kenema** and **Moyamba**. The analysis was mostly based on 18 key informant interviews of DHMT, NGO and donor staff at district level (**Figure 2**).

Figure 2: characteristics of key informants at district level (n=18)



To triangulate this information, data from a survey of 266 primary (PHU) health workers focusing on their incomes were also used. In order to analyze the interviews, a **political economy framework** was adopted which focuses on the dynamic interactions between structure (context, historical legacies, institutions) and agency (actors, agendas, power relations) to show how these elements affect the HRH incentive practices in each district.

Findings

HRH policies and reforms faced a series of challenges in their implementation **nation-wide**:

- Little HRH management is performed at district level by DHMTs, who have no power to recruit locally.
- Payroll is increasingly imprecise and salaries are not paid to some health workers (15% of sample in PHUs)
- Delays in payment of PBF bonus of about 1 year
- Payment of remote allowance delayed in 2012 and stopped by the end of 2012
- Poor communication of reforms, roles and tasks between levels of MoH (central and district)
- This led to the general frustration of actors working at local level, who see policies being introduced but rarely effectively implemented.

The effective implementation of policies and reforms seems even more complicated when we look at factors at **district level**. The three districts are different in terms of **number and type of NGOs presence** – this seems to partially depend on historical legacies as some NGOs intervened during the war and in the immediate post-conflict in the areas that were most affected and some remained there overtime. Other NGOs established their presence more recently.

Moreover, NGOs differ in terms of their **agendas and priorities** (e.g., humanitarian vs. development, service/disease-specific vs. broad health system support). Finally, NGOs have different **will, capacity and need to collaborate with local health authorities**. Some actively participate in district coordination meetings, some prefer bilateral discussions with DHMTs, some operate rather independently.

There seems to be a substantial asymmetry of power between the DHMTs, which have little financial and human resources and little information about the NGOs' plans and resources, and NGOs, who are capable of partially re-orienting the local health priorities and practices. In terms of HRH, the results of the negotiation is the creation of **'informal' HRH incentive practices** that aim to ensure a better fit between the external actors' agendas and the health worker incentive packages. For example, NGOs may decide to introduce selective supervision, salary supplementations, and training and DSA for *some* PHUs and/or *some* disease/services (e.g. for nutrition only, or for MCH/PBF indicators, etc.). In turn, this results in statistically significant differences in the non-salary incomes for primary health workers across districts (**Table 1**).

Table 1: Average income of PHU staff in the three districts (Leones)

District	PBF	DSA	salary	Total income
Kenema	102,392	207,722	491,276	849,903
Bo	57,112	134,132	516,984	786,986
Moyamba	92,985	109,966	484,913	719,854

Note: 1 USD = 4,270 Leones (October 2013).

In conclusion, the official HRH policies defined at central level are re-shaped and modified, both because of their implementation challenges and because of the informal practices that emerge as the result of the district-level dynamics and negotiations between District Health Management Teams (DHMTs) and external actor, such as non-governmental organisations.

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Recommendations

The EVD and post-EVD context may provide a new "window of opportunity" for political and financial support to health reforms. It will be essential to learn from the experience of Sierra Leone and other countries[4] and to adopt new approaches to health system strengthening[5]. Useful lessons can be also learned from this research:

- It is important to keep the momentum generated in support of policies after the design phase, to include also their **implementation**. Deep structural and institutional changes are needed at all levels of the system (central and district) to ensure that effective implementation is sustained beyond the short/medium-term provision of technical assistance.

- **DHMTs** should be empowered to ensure their coordination role at local level. Essential tools include: increased financial and human resources, improved skills and capacity, widened decision-spaces, and openly shared objectives and agendas. Realistic and contextualized planning, budgeting and reporting should be strengthened under the DHMT leadership so that it would (i) define in advance a plan of activities and tasks, based on the nationally-defined health priorities, adapted to the local context. Such plan should leave room for flexibility and adaptation to the evolving context and potential stressors (such as the EVD outbreak); (ii) identify those responsible to carry activities out and when; and (iii) include *all* resources available, from internal and external sources, in a transparent and predictable manner. The latter could be done through district-level 'basket funds', by pooling resources available and envisaging a funding mechanism linked to the accomplishment of each task, which would hold actors accountable for their performance under the same contractual framework.

- There is a need to actively reflect on the **post-crisis legacies** in the presence and distribution of external actors (e.g. which NGOs/donors are active where? Doing what? For how long?), to help avoiding disparities in health worker remuneration and health service provision across districts. This includes managing and coordinating the exit strategies of the NGOs currently present in Sierra Leone to avoid areas inequities and to ensure nation-wide coherence of interventions with MoHS policies.

Signs for nutritional services supported by different funders outside of a PHU in Moyamba (funders'/NGOs' logos concealed - *Photo credit: MP Bertone*)

Notes

[1] Wurie, H., Samai, M.H., Witter, S., 2014. *Staffing the public health sector in Sierra Leone, 2005-11: findings from routine data analysis*. ReBUILD Consortium. (http://bit.ly/1KVV7iC)

[2] Bertone MP, Samai M, Edem-Hotah J, Witter S (2014), A window of opportunity for reform in post-conflict settings? The case of Human Resources for Health policies in Sierra Leone, 2002–2012, *Conflict and Health*, 8:11 (www.conflictandhealth.com/content/8/1/11), and policy brief by the ReBUILD Consortium (http://bit.ly/1X49VPN)

[3] Witter S, Wurie H, Bertone MP (2015), The Free Health Care Initiative: how has it affected health workers in Sierra Leone? *Health Policy and Planning*. (http://bit.ly/1jK81Ya)

[4] McPake B, et al (2015) Ebola in the context of conflict affected states and health systems: case studies of Northern Uganda and Sierra Leone. *Conflict and Health*, 9: 23. Available at: (http://www.conflictandhealth.com/content/9/1/23)

[5] Denney L, Mallett R (2015), *After Ebola: why and how capacity support to Sierra Leone's health sector needs to change*. London, Overseas Development Institute (http://www.securelivelihoods.org/publications_details.aspx?resourceid=362)

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This study was carried out by researchers at the **London School of Hygiene and Tropical Medicine** (LSHTM) as an **affiliate project** under the ReBUILD research consortium. The **ReBUILD Consortium** is a research partnership funded by the UK Department for International Development. Led by the Liverpool School of Tropical Medicine and the Queen Margaret University (Edinburgh) in the UK, ReBUILD works with partners in Cambodia, Sierra Leone, Uganda and Zimbabwe to explore ways to strengthen policy and practice on health financing and human resources.
For information on ReBUILD research, visit **www.rebuildconsortium.com** or follow on Twitter **@ReBUILDRPC**

The **LSHTM affiliate project** in Sierra Leone focuses on the financial incentive environment for health workers which was shaped in the post-conflict period, and aims at describing the multiple remunerations available for primary health workers, the causes and determinants of the variation in earnings at individual, facility and district level, as well as the implications of such remuneration structure.
Further information on the affiliate project and outputs, including all policy briefs, are available at http://bit.ly/1FI9tnG or contacting Maria Bertone - **maria.bertone@lshtm.ac.uk**

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