



Evidence for supporting a skilled health workforce for all in Sierra Leone

The ReBUILD Research Programme Consortium has been conducting research on human resources for health and health systems financing in Sierra Leone since 2011. With extensive research findings from before and during the 2014-15 Ebola outbreak, ReBUILD's work is very relevant for the ongoing health sector reconstruction process post Ebola. This brief outlines ReBUILD's research on health worker incentives, and gives recommendations for the ongoing recovery strategy, based on the research findings, focusing on the strand for increasing a skilled workforce, especially in under-served areas.

The ReBUILD RPC in Sierra Leone

ReBUILD's research in Sierra Leone is led by the **College of Medicine and Allied Health Sciences (COMAHS)**, University of Sierra Leone, the country's main health training institution, with strong links with the Ministry of Health and Sanitation (MOHS).

The projects cover: (i) health financing and its effect on poor households, and (ii) health worker incentives and retention, post-conflict and during shocks (including the Ebola outbreak). Gender and equity are mainstreamed through all ReBUILD's work.

ReBUILD's research on health worker incentives in Sierra Leone

Research aim: To understand the post-crisis dynamics for human resources for health and

ultimately how to reach and maintain incentives to support access to affordable, appropriate and equitable health services.

Research questions:

How has HRH policy evolved during and post-crisis?

What incentives are available for health workers?

What have been the implementation challenges and the effects of the incentives programmes?

How have shocks such as conflict and Ebola affected health workers and how did they cope?

What can we learn from this about supporting an effective and well distributed health workforce?

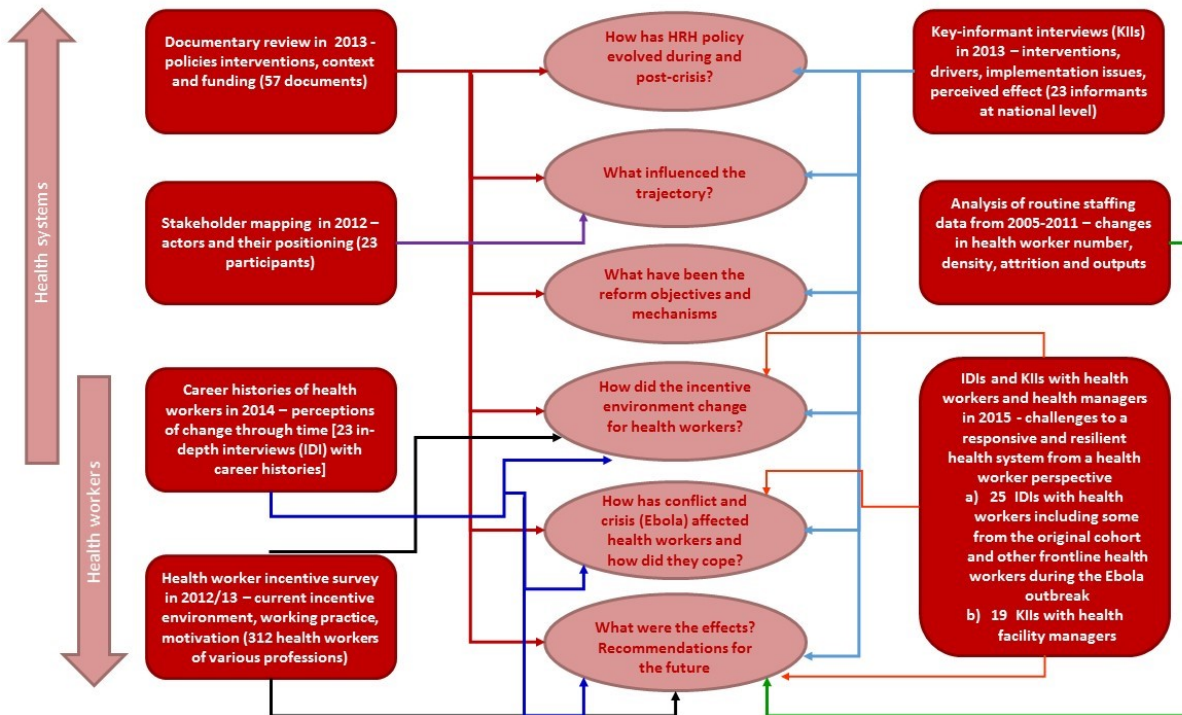


Figure 1 ReBUILD health worker incentives research, Sierra Leone: summary of research tools

Study areas and methodology:

ReBUILD used six study tools, applied across four districts. The sites were: Western Area (Urban/Rural), Kenema (Eastern Region), Bonthe (Southern Region) and Koinadugu (Northern Region). Study tools are shown in Figure 1. Full details of the above methodology and the detailed findings are available in a series of research reports (<http://bit.ly/1jzJXXP> and further information below).

An additional affiliate research project focused specifically on financial incentives for health workers, in three districts: Bo, Kenema and Moyamba from September 2013 to May 2014. Tools used included 18 key-informant interviews at district level; survey of 266 primary (PHU) health workers focusing on their incomes; logbook filled in by the same 266 health workers reporting daily activities carried out and incomes, and 39 in-depth interviews of a sub-sample of the same health worker (outputs are available at: <http://bit.ly/1FI9tnG>).

Some key findings

Evolution of policy

Analysis of HRH policy evolution post-conflict in Sierra Leone found that there was a long period during which the Ministry of Health and Sanitation (MoHS) attempted to regain leadership. While a number of formal policies were developed, with partner support, it was not until the launch of the Free Health Care Initiative (FHCI) in 2009/10 that a

sweep of reforms took place, including increased salaries, payroll cleaning, local recruitment, attendance monitoring and later performance-based funding (PBF) and the introduction of the rural area allowance (RAA).

The announcement of the FHCI created a momentum for collective action and renewed partnership between the different stakeholders in the health sector. However, beyond the FHCI preparatory period, this collaboration between the MoHS and partners seemed to diminish.

While there is evidence of improvements in HRH (pre -Ebola at least), linked to the FHCI, more ‘complex’ reforms relating to decentralisation of recruitment and deployment, tackling pre-service training requirements, and ensuring adequate working conditions for health workers, especially in rural areas, were over-looked.

Incentives and their implementation

The salary increase under the FHCI was highly skewed towards the higher grades (see figure 2 overleaf). While the aim of the salary increase was to attract health workers, reward them for their increased workload and replace informal fees, the disproportionately higher increase in the salaries of higher cadres (i.e. doctors) was not justified based on these objectives. Problems have been recorded (from a number of sources) with the reliability of the rural area allowance and the PBF payments.

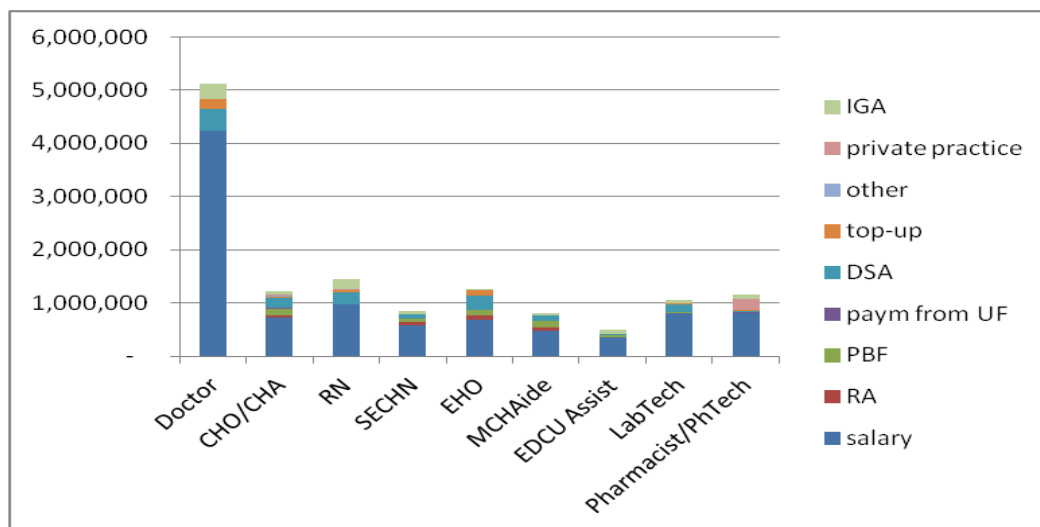


Figure 2
Breakdown of total sources of health worker income, by profession (ReBUILD survey, 2012, Leones)

From the affiliate research, it emerged that salary represent about 60% of the total income of health workers in PHUs. The remaining earnings [per diems (18%), PBF (10%), gifts (5%), and income-generating activities outside of the health sector (4%)] represent a potentially relevant motivation for staff, but which is poorly mastered at central level.

Effects of reforms to incentives

- ReBUILD studies concluded that the FHCI had a major effect on health workers in Sierra Leone, triggering a series of reforms which significantly changed their number, pay and attendance. It also increased their workload, though this has yet to be fully quantified given gaps in the health information system.
- The overall national attrition rate for health workers fell from 5-6% at the start of the period to 3-4% at the end. This was highly variable between cadres, with higher cadres more likely to leave the service. A number of senior positions, such as registrars, remained unfilled, and absolute numbers of staff remained low for a number of key cadres, including midwives.
- Overall, reported motivation has improved, though there remain tensions between different cadres (higher level staff benefited more than lower level staff) as well as a demand for a more consistent package of financial and non-financial incentives, particularly in rural areas.
- The data showed improvements in the national level of absenteeism after the implementation of the Staff Sanction Framework and its accompanying attendance monitoring tool. National levels of absenteeism reduced to 1.1% in February 2014 from 12.5% in December 2010, if reporting of absenteeism remains robust.

- Despite a relative reduction in 2011, the output per health worker was higher post-FHCI than before for both general services and maternal health care, in districts for which data could be obtained.
- Remaining challenges include filling essential positions, ensuring an even distribution of staff across the districts, maintaining a strong downward pressure on absenteeism, and further reducing attrition.

Current challenges for retention and motivation of health workers

Interviews with health workers suggest that current retention challenges can be attributed to the level of income earned not being in line with the cost of living, non-implementation of HRH incentive policies where they exist, problems with deployment and management of personnel (including political interference in postings, poor relationships with colleagues and the administrative hierarchy in discipline and career management), poor systems for motivation, poor working conditions, limited provision for individual professional capacity development (regional disparities in urban vs rural; less access for women) and the lack of an appropriate retention package for rural posted health workers.

When health staff were asked to rank factors motivating them to work in order of importance, salary emerged as the most highly ranked, followed by opportunities for training and additional allowances/opportunities to serve the community.

Financial incentives alone are not enough to motivate health workers in rural areas. Reasons for poor retention include lack of accommodation, poor access to basic amenities for personal and professional use, weak transport infrastructure and irregularities in financial incentive packages (Figure 3 overleaf).

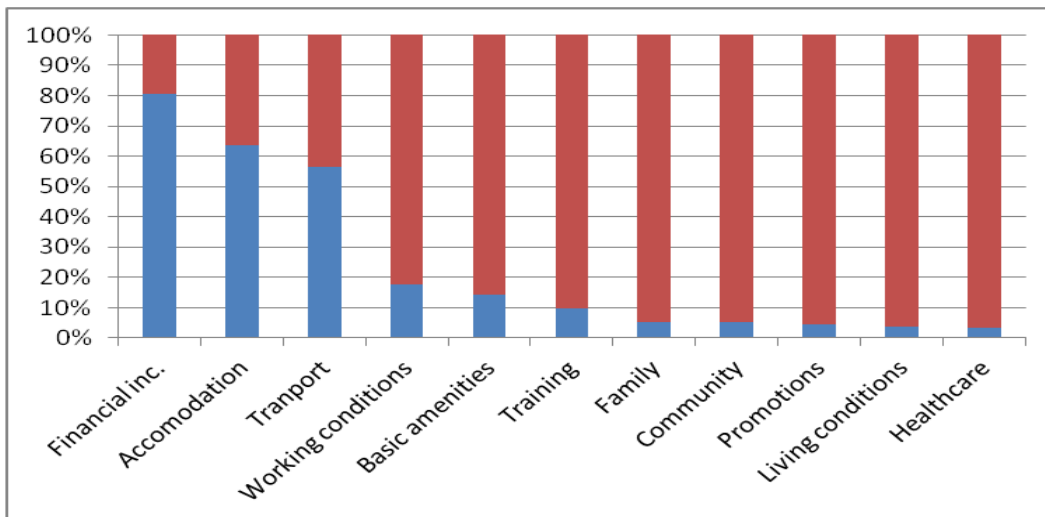


Figure 3 Summary of main phrases for what would motivate staff to serve in rural areas (ReBUILD survey 2012)

Main themes emerging when staff were asked about what would motivate to serve in rural areas were:

- Accommodation
- Financial incentives (salary increase, remote and/or risk allowance, incentives, etc.)
- Support to family (school fees, scholarships for children, family and children facilities, etc.)
- Communication support and allowances
- Transport support (transport allowance, mobility, motorbike, vehicle, fuel, etc.)
- Access to basic amenities (water, electricity, toilet, food, basic facilities)
- Training (more education and training for the health workers)
- Improved living conditions (improvement of social opportunities, social amenities, relationship with communities, etc.)
- Promotions (linked to rural posting)
- Investment in working conditions (improvement of working conditions, relationship with colleagues, support/supervision, more staff, equipment and drug availability)
- Provision of healthcare for health workers

Recommendations for increasing a skilled workforce especially in under-served areas

This work is very relevant for the ongoing strategy for health sector reconstruction post-Ebola, and the strand on increasing a skilled workforce, especially in under-served areas.

Overarching recommendations:

1. Learning lessons from the past, Sierra Leone must seize the opportunity offered by international interest in health sector reconstruction post-Ebola. The ReBUILD research emphasises the need to develop a coherent overall package, focussing on implementation and follow-through, with good alignment of government and partners.
2. Specifically, good communication between the finance and HR directorates in the MoHS and between national level and districts are required.
3. For all human resource for health (HRH) functions, a well functioning HR information system is critical. This has been planned for some years but not delivered.
4. Capacity for effective human resource management at MoHS and District Health Management Team level is needed to reduce dependence on external technical support
5. The recruitment process for health workers is too centralised and can cause long delays, allowing local managers no role in staff selection and performance management. The new Health Service Commission should address this.
6. Decentralisation of the process might also reduce the time which is currently taken to engage new staff, something which causes demotivation and attrition.
7. A full package of measures should be introduced to address the rural/urban divide for health staff, beyond the currently erratic RAA to include: specific tours of duty (e.g. 2 years), which are respected; preferential training access for those working in rural areas; and provision of housing close to facilities (especially for female staff)

Revising the remuneration package:

1. The revised remuneration package needs to strike a balance across the cadres.
2. The PBF scheme should be reformed so that payments are regular (monthly, rather than quarterly), paid on time, and transparent. It was clear that as well as the financial top-up, health workers appreciated getting feedback on their work in the form of an appraisal system. Provision of this in a supportive way should be built into the PBF process.
3. The remote area allowance should be reviewed to establish the additional costs of working in rural areas. It is not just a motivation scheme but also needs to cover the extra costs which health workers face. Greater involvement in its design would also ensure that health workers understand how it is meant to operate.
4. Payroll management needs improving to reduce delays in getting on payroll.
5. Systemic problems in paying financial top-ups should be addressed. The risk allowance during the Ebola response was the most recent example of an allowance not being received reliably by health staff, causing frustration and demotivation.
6. Better alignment and coordination of NGOs' activities to support health workers is needed, to avoid disparities between cadres and districts, e.g. differences in the level of per diem payments and in support provided to services related to PBF (which in turn increases PBF bonuses in some districts).
7. Efforts made to improve motivation and staff presence in rural areas during the EVD outbreak through provision of financial

incentives should be maintained. NGO and donors' exit strategies and the removal of incentives should be coordinated and managed in order to avoid demotivation, and further exacerbating the mal-distribution of the health workforce, with remote and hard to reach areas being at a disadvantage.

Strengthening career pathways:

1. Routes into the medical profession for those of low income should be encouraged as it is likely that these staff, especially if mid-level, will more easily be retained in rural areas.
2. The development of a career structure with options for progression in pay and responsibility for CHOs should be developed (e.g. through the Scheme of Service which is currently being developed for Health Workers in Sierra Leone).
3. Direct entry into midwifery training should be considered to address severe shortfalls in this cadre.

Continuing professional development:

1. Regional disparities in access to training should be addressed, reversing the bias, so that those serving in rural areas have higher chances of training
2. Given the additional domestic responsibilities of women, supportive measures should be put in place to support them in accessing and taking up training opportunities
3. CPD activities should be linked in as mandatory to career progression.

For more information, see reports cited above and also:

Bertone, M. and Witter, S. (2015) An exploration of the political economy dynamics shaping health worker incentives in three districts in Sierra Leone. *Social Science and Medicine*, volume 141, pp56-63. <http://www.sciencedirect.com/science/article/pii/S0277953615300447>

Witter, S., Wurie, H. And Bertone, M. (2015) The Free Health Care Initiative: how has it affected health work-

ers in Sierra Leone? *Health Policy and Planning* journal, 1-9 <http://heapol.oxfordjournals.org/content/early/2015/03/21/heapol.czv006.full.pdf?keytype=ref&ijkey=VPzC5PJtxdrYeKa>

Bertone, M., Samai, M., Edem-Hotah, J. and 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. <http://www.conflictandhealth.com/content/pdf/1752-1505-8-11.pdf>



What is the ReBUILD Consortium?

The ReBUILD Consortium is a 6-year research partnership, funded by the UK Department for International Development (2011-17), working with partners in Cambodia, Sierra Leone, Uganda, Zimbabwe and through 'affiliate' partners in other post-conflict countries. ReBUILD's aim is to improve access of the poor to effective health care and reduced health costs burdens, through the production and communication of robust, policy-relevant evidence on health financing and human resources for health.

Why focus on post-conflict contexts?

In countries affected by socio-economic crisis or conflict, health systems break down and external emergency assistance is often the main source of care. As recovery begins, so should the process of rebuilding health systems. But health systems research has neglected post-conflict contexts and not enough is known on the effectiveness of different approaches. ReBUILD has been created to address this challenge. The relevance of its findings are enhanced by further shocks to the health system like Ebola.

Find out more on ReBUILD's work in Sierra Leone and beyond

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Explore: ReBUILD's new resource on gender and post-conflict health systems **Building Back Better** www.buildingbackbetter.org and for more on our work to galvanise gender and ethics analysis in health systems, see <http://resyst.lshtm.ac.uk/rings>

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