HUMAN RESOURCES FOR HEALTH SUMMIT

2-3 JUNE 2016

FREETOWN, SIERRA LEONE

Executive summary

From June 2-3, 2016, Sierra Leone's Ministry of Health and Sanitation (MoHS), with support from the Clinton Health Access Initiative (CHAI) and the World Health Organization (WHO), convened a Human Resources for Health (HRH) Summit in Freetown. The Summit aimed to provide a platform for experts on HRH to share experiences and expertise on best practices and policies for strengthening HRH policy and strategy (across the spectrum from doctors to community health workers) as well as create an opportunity for relevant stakeholders to discuss and agree on key policy pathways for improving HRH. In short, the Summit kick-started a policy process to refresh and relaunch Sierra Leone's HRH Policy and Strategic Plan by the end of 2016.

The Minister of Health and Sanitation, Dr Abu Bakarr Fofanah, opened the Summit and joined many members of the Ministry's senior leadership to commit their full support to the Summit's aims and subsequent policy process. The Directorate of Human Resources presented updated data on the current health workforce and reviewed lessons from Sierra Leone's past HRH experience. Experts from Liberia, Ethiopia, Zambia, Malawi, Rwanda, Uganda and Ghana shared HRH successes and challenges from their respective experiences. The workshop also examined four key technical areas of HRH policy and strategy: 1) pre-service and in-service training 2) recruitment and workforce planning 3) performance management, motivation and regulation, and 4) governance and decentralisation. Areas 1 and 3 were discussed in cadre-specific working groups. Areas 2 and 4 were covered using presentations and panel discussions. Technical sessions were complemented by a panel of Health Development Partners sharing priorities for their programmes. The workshop concluded with a briefing on the next steps in the strategic policy process with working groups being constituted to begin an inclusive and consultative process to develop a refreshed policy and strategic plan by the end of the year.

The report which follows summarizes these discussions. The workshop was attended by 190 participants from over 10 different countries, and the full list of participants is included in Annex 1. The Summit Agenda is included in Annex 2 and a brief outline of the timeline for Sierra Leone's refreshed HRH policy and strategy in Annex 3. Presentations from the Summit are available online and can be accessed through the following link:

Link to HRH Working Group Dropbox – HRH Summit 2-3 June Folder

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Introduction

Background

Close to 300 health workers died during Sierra Leone's Ebola crisis exacerbating an already severely challenged health workforce and highlighting the critical role of human resources for health (HRH) for building and maintaining a resilient health system. Sierra Leone suffers a serious shortage of health workers. The distribution and retention of health workers throughout the districts also pose significant challenges for HRH in Sierra Leone.

While the Ministry of Health and Sanitation (MoHS) prepared a Human Resources for Health Policy in 2012 and Human Resources for Health Strategic Plan (2012–2016), the implementation and impact of these policies and plans were limited by Ebola. The Government in Sierra Leone recently implemented a 6-9 post-Ebola Recovery Plan and has transitioned to a 10-24 month post-Ebola Recovery Plan which is now known as the President's Recovery Plan (PRP). This includes a focus on the need to "*build a resilient workforce through improved production, clinical mentoring, retention, attendance and distribution of health workforce facilities with an adequate number of staff*."

To complement these efforts, the Ministry of Health and Sanitation (MoHS), with support from WHO and CHAI, is updating its Human Resources Information System (HRIS) and creating an updated Human Resources for Health Country Profile. In order to provide further guidance on the key strategic decisions for the development of a new Strategic Plan, the MoHS, with support from WHO and CHAI, planned and organized a two-day high-level political and policy Human Resources for Health Summit.

Rational

Preparing a robust and realistic HRH Strategic Plan requires accurate information on HRH in Sierra Leone as well as guidance and agreement on interventions. To ensure success, this requires both high-level political commitment and critical reflection on the challenges faced in implementing past policies and strategies and expertise for assessing why past efforts might not have succeeded. To complement and contextualize Sierra Leone's experience, it is also important to learn from and build upon other countries' experiences. Accordingly, this Summit convened leading experts and authorities on HRH from both within and beyond the country to create a forum for sharing expertise and best practices.

Objectives

The Summit aimed to:

1. Provide a platform for experts on HRH to share experiences as well as provide guidance and expertise on best practices, policies and strategies for strengthening HRH policy and strategy (across the spectrum from doctors to community health workers) in Sierra Leone.
2. Create an opportunity for relevant stakeholders to discuss and agree on key strategies and policy pathways for improving HRH in Sierra Leone in the short and medium term.

Expected Outputs/Outcomes

The Summit was expected to:

1. Provide input into priority strategies and interventions for strengthening HRH in Sierra Leone; and

2. Define a policy process and road map for developing a new HRH Policy and Strategic Plan.

The two-day Summit started with updated information on the current health workforce and reviewed lessons from Sierra Leone's past HRH experience. The Summit convened an impressive panel of experts from Liberia, Ethiopia, Zambia, Malawi and Ghana presenting their national HRH experiences including successes and challenges. The second part of the workshop examined four key technical areas of HRH policy and strategy: 1) pre-service and in-service training 2) recruitment and workforce planning 3) performance management, motivation and regulation, and 4) governance and decentralisation. Areas 2 and 4 were covered using presentations and panel discussions while areas 1 and 3 were discussed in cadre-specific working groups. Technical sessions were complemented by a panel of Health Development Partners sharing priorities for their programmes. The summit concluded with a briefing on the next steps in the strategic planning process. The full programme is given in Annex 2.

The summit was attended by 190 participants from over 10 different countries. The list of participants is given in Annex 1. Presentations are available online and can be accessed using the following link:

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1. Proceedings for day 1: June 2nd, 2016

1.1. Opening and Ministerial Session: The Vision for Human Resources for Health in Sierra Leone

The Chairperson of the Summit, Mr. David Banya, Permanent Secretary of the MoHS and his co-chair, Dr. Amara Jambai, Deputy Chief Medical Officer II of the MoHS, welcomed participants and explained the purpose of the meeting and the need for effective HRH policies to strengthen the delivery of healthcare. The Chief Medical Officer, Dr. Brima Kargbo, particularly welcomed participants from abroad to the Summit. He explained that the work on human resources was part of a wider health plan and expected that the efforts of this workshop would be an important part of the process of developing policies and plans for HRH. The Minister of Local Government and Rural Development, Mr. Maya Kaikai, confirmed that his ministry would work with the MoHS to strengthen health services in rural areas and stressed the need for better collaboration between both ministries. The Minister of State, Ministry of Finance and Economic Development, Mr. Patrick Conteh, pointed out the timeliness of this initiative in the post-Ebola period as the strategy aims to develop a resilient health workforce and promised “unflinching support” for the MoHS. The Minister of Education from Liberia, Mr. George Werner, suggested Sierra Leone should consider the nexus of health, education and economics. Economic growth is needed to expand services in both areas. People need good education in science and maths to be able to become doctors and nurses.

The Minister of Health and Sanitation, Dr. Abu Bakarr Fofanah, delivered the keynote address and official opening statement. He explained that Sierra Leone is now implementing the second Ebola recovery and transition plan and moving towards addressing the new Sustainable Development Goals, both of which are needed to address HRH challenges. Dr. Fofanah reiterated the importance of strategic thinking for addressing HRH problems. Central to the development of the HRH strategy is: 1) Leadership and governance for effective stewardship of HRH development; 2) Education and training in line with people-centred health service delivery; 3) Investment in data and evidence for sound decision-making; 4) Planning based on sound understanding of health labour markets; and 5) Employing health workers where they are needed and harnessing the private sector.

The Minister cited progress made already in the past year but emphasised the need for a new plan to address all HRH challenges. He then declared the summit open.

1.2. Roadmap and objectives for Sierra Leone’s refreshed HRH Policy and Strategic Plan

Dr. Jambai, Deputy Chief Medical Officer II of the MoHS, moderated this session and reiterated the importance of ‘resetting’ the health sector in the post-EVD phase. This made the summit very timely, thereby creating a platform for concerted multi-sectoral planning for the HRH pillar, as we move forward.

This session was titled ‘*A roadmap for Sierra Leone’s refreshed HRH Policy and Strategic Plan’.* The presentation started by defining the HRH sector. It shared an overview of the current HRH sector in Sierra Leone and concluded with an overview of the HRH Strategic Plan process.

1.2.1. Defining the human resources for health sector

Mr. Samuel Coker, Director of HRH at the MoHS, introduced the presentation and explained that the basis of the summit was to support Sierra Leone’s efforts in reconstructing the national HRH Policy

and Strategy, building on past efforts and previous policy documents including the HRH Country Profile (2011), HRH Policy (2012) and HRH Strategic Plan (2012-2016).

The summit kick-starts a new process and new HRH policy direction taking into account the key achievements of the ongoing post-EVD health sector recovery plan. Early post-Ebola recovery efforts brought new focus and energy to the HRH space, with some of the key achievements of the 6-9 month including population of the HRIS, and the creation of a health worker pipeline model and a payroll verification exercise. Collectively, this creates a platform to facilitate informed decision-making and strategic planning for a refreshed HRH Strategic Plan, contributing to improvements in the quantity, quality and distribution of the health workforce.

1.2.2. Reviewing the current HRH landscape in Sierra Leone

Mr. Emile Koroma, Human Resource Manager at the MoHS, continued the presentation, defining HRH using four areas (education, recruitment and finance, performance and regulation and governance) encompassing steps in a health worker's pathway to delivering services. He highlighted challenges across these four areas. For example, in-service training is not effectively coordinated and is being offered by multiple actors with some training institutions currently operating without accreditation. Another challenge is that HR management is highly centralized, with recruitment, deployment, inter-district transfer and leave approval all being coordinated at the national level. However, some transfer decisions can be made at the district level and "informal recruitment" of unemployed health workers volunteering takes place at the facility level without prior knowledge at the national level. Workforce data management was also described as a priority challenge, with iHRIS currently being introduced and institutionalized to redress the situation.

He further explained the current state of HRH based on recently collected data on the active workforce as part of a nation-wide exercise to audit the MoHS payroll. He gave ten key points to understand SL health workforce challenges and provided further insights to the current health workforce landscape. These challenges were grouped under four main areas: number, quality assurance, distribution and cost, as shown in the figure below:

Figure 1: Ten key points to understand health workforce challenges in Sierra Leone

Area	Key points
Number	1. Health worker shortages remain a persistent challenge for Sierra Leone 2. Without intervention, these gaps will remain 3. However, the total workforce is larger than previously understood, with considerable numbers of unsalaried workers 4. Gaps vary by cadre, with challenges for SRNs, midwives, medical officers 5. A significant number of high-skilled HWs are also in admin roles
Quality Assurance	6. A significant portion of the active workforce appears to be unlicensed
Distribution	7. Access to health workers is heavily concentrated in urban areas 8. Most work at hospitals, leaving rural facilities with low staffing levels 9. Districts with a large workforce still have significant facility-level gaps
Cost	10. Keeping the payroll clean can help address some challenges but will not be sufficient to create fiscal space for a workforce that meets staffing norms

Despite increases in the health workforce from the 2010 Free Healthcare Initiative, one of the biggest challenges is a critical shortage of health workers. The EVD outbreak further depleted this number and the health workforce number remains below national staffing norms and international comparisons. Currently, there are gaps across every cadre, with some greater than others. For example, higher nursing cadres like SRNs and specialist nurses are critically low, while lower cadre nurses, like State Enrolled Community Health Nurses meet targets. Without any intervention, Sierra Leone will not meet its current Basic Package of Essential Health Services (BPEHS) staffing norms over the next ten years.

Another challenge is that unsalaried workers, mostly lower-cadre health workers, are actively working in public health facilities. Taking them into account would reduce some gaps. However, gaps in higher-skilled cadres further increase when accounting for higher-skilled workers working as administrators rather than clinicians. Over one-third of all medical specialists are serving in administrative roles rather than providing clinical care. The brain drain phenomenon also has a negative impact on health worker numbers, particularly amongst the higher cadres. Sierra Leone has a large diaspora practicing in other countries (diaspora data is limited, but international census data shows at least 249 physicians born in Sierra Leone were living abroad in 2000, and a recent survey conducted by IOM identified 500 Sierra Leonean health workers in Germany, Canada, the US and the UK.)

On quality, another data point collected as part of the Health Workforce Audit was health worker license status. From the collected data, over 33% of all clinical health workers serving in facilities could not produce a license during the verification exercise. Included in this were CHOs, who currently do not have a regulatory body. Distribution of the health workforce is another key challenge. Health workers are highly concentrated in the capital city, Freetown, and the four regional headquarters. Three quarters (74%) of the total health workforce is active in only 10% of facilities. Furthermore, most health workers are based in hospitals, leaving primary health facilities not meeting the recommended clinical staffing norms as stated in the BPEHS.

The recently conducted payroll audit was unable to verify 756 health workers, out of the 10,166 on payroll. Removing these health workers from the payroll should result in an annual saving of approximately $2 million (10% of the MOHS wage bill), freeing up fiscal space to absorb volunteers into the health workforce. However, meeting the recommended staffing norms in the BPEHS will add to the wage bill significantly.

1.2.3. The next steps to develop a refreshed HRH Strategic Plan

The HRH Strategic Plan will be developed in the next six months. With engagement from relevant government agencies, regulatory boards and councils, training institutions, health facilities, professional associations, cadre-specific representatives, civil society and development partners, the process will be highly consultative. The HRH strategic planning process will complement and be aligned with ongoing planning and policy processes.

The summit started discussions around four areas used to define HRH in Sierra Leone, guided by pre-prepared questions. These include: How can pre-service training be best coordinated amongst MoHS, Ministry of Education Science and Technology (MEST) and the private sector to match supply with demand? What are the existing bottlenecks and barriers for public sector recruitment and financing? What is the process by which HRH decision-making should occur across the central and district levels, and what specific decisions can be decentralized? What are the best practices by which workers are licensed, regulated and monitored, and training institutions are accredited, in other countries?

These will be explored further in the sections below.

1.2.4. Questions and discussion session

Dr. TT Samba, District Medical Officer for the Western Area, emphasized the importance of strengthening all six health systems building blocks simultaneously and not in isolation to ensure we rebuild a resilient health system. This should be further supported by ensuring that four conditions, namely correct staff, skills, functioning support system and an enabling environment, should be in place as recommended by the World Health Organization. He also raised concerns regarding employee welfare, staff retention, career pathway development, motivating staff and staff postings.

A representative from the Tertiary Education Commission (TEC) commented on the co-existence of MEST and MoHS, and highly recommended that the TEC should work closely with these two ministries. He recommended regulatory bodies should be further strengthened to address some of the challenges mentioned. It was also recommended that the newly established school of postgraduate studies and clinical sciences should work in line with the TEC and Directorate of Higher Education and be aligned with the regional institutions and local training institutions.

The Assistant Minister in charge of Policy and Planning in the Ministry of Health (MOH) Liberia, Benedict C. Harris shared insights into the HRH unit at the MOH in Liberia, which was further sub-divided in three blocks: HRH planning, Recruitment and Management.

The Chief Nursing and Midwifery Officer, Matron Hossinatu Kanu, commented that nurses and midwives are only being prioritized on paper, even though they make up 60-70% of the total health workforce. She also raised concerns about education programs for these cadres and how it is being handled by the MEST and the private sector. These challenges include the aforementioned non-accredited courses being offered and suggested that support is needed from MEST and MoHS to support the efforts of the regulatory bodies.

Mr. M. R. Koroma from the Health Service Commission, encouraged summit participants to think outside the box in addressing the above raised issues, and that policy has to be reflective of is the reality on the ground. For example, given the maldistribution of the current workforce, we should aspire to develop a more robust referral system.

1.3. Setting the Scene: Learning from past HRH experience in Sierra Leone

Roundtable discussion with local experts, moderated by Anders Nordstrom, WHO Representative

The moderator started the discussion by asking each panelist to answer briefly two questions: 1) What should be remembered from past HRH experiences? 2) What is your key priority recommendation?

1.3.1. Dr. Joan Shepherd- Principal, National School of Midwifery

The nursing profession has been reduced to a course for drop-outs. Its members are largely in the cadres of MCH Aides, Nursing Aides, and SECHNs. This is because most students who opt for nursing do not meet the academic requirements, and are encouraged to pursue lower nursing cadre courses. The curriculum for the nursing administrators and educators needs review. Career paths in nursing are limited and unclear. Most of the senior nurses with good clinical skills are shifting to public health. 98% of nurses with MSc work for NGOs in non-clinical functions.

1.3.2. Dr. Len Gordon-Harris: Senior Lecturer, College of Medicine and Allied Health Services (COMAHS)

COMAHS was started in 1988 with only 3 lectures. We should not wait until conditions are ideal before starting something progressive. In 1992, there was a much structured health system, with 10 Obstetrician/Gynecologists, 8 surgeons, 8 physicians, and 7 pediatricians, in active civil service.

Hospital administration was strict and every regional hospital had 1 specialist in the main disciplines. A post-graduate committee was set up about 2 years ago, with Dr Gordon-Harris as chairman. It is imperative for this medical post-graduate program to have started now, otherwise HRH will diminish. Presently, about 40 doctors are being trained in different parts of Africa.

1.3.3. Dr. Effie Gooding- Coordinator of the post graduate programme, HSS Hub

30 years ago, when doctors graduated from medical school, they were immediately appointed into the civil service with a car allowance and accommodation. In recent years, doctors remain unemployed for up to six months following graduation from medical school. Once they are employed it takes another six months for them to get their first salary.

In 2009, WHO sent two consultants to develop a local postgraduate training plan, because some doctors were not returning after specialist training overseas. In the last six months, a teaching hospital act has been enacted and accreditations for surgery, pediatrics and family medicine have been obtained. In the next three to six months, accreditations in obstetrics and gynecology and internal medicine should be obtained. Post-graduate training will hopefully begin later this year. By 2019, 15 specialists should have been trained in five disciplines (O&G, surgery, internal medicine, pediatrics and family medicine) from the West African Postgraduate Training Colleges. By 2017, the Sierra Leone Postgraduate College will be fully established with its first set of graduates by 2020.

The necessary requirements are strong ccommitment from the government of Sierra Leone, with immediate recruitment and improved conditions of service as well as a reconsideration of scholarships for specialist training abroad.

Response from Liberia's Minister of Education, George K. Werner: Training should be seen as a mutually inclusive affair. Scholarship opportunities should not be limited. A memorandum of understanding could be established between the ministry of education/health and international institutions.

1.3.4. Dr. Patrick Coker – Senior private practitioner

Most private practitioners have retired from civil service but had a two-year overlap between civil service and private practice. Young doctors graduating from medical school should be immediately employed and doctors should improve their attitudes. There is a lack of satisfaction in terms of salary scale, conditions of service, tools and equipment to make work more efficient. There are also few opportunities for further education. Private doctors should come together to improve patient care. The MoHS looks at private practitioners as outsiders, as private practitioners cannot admit patients to government hospitals. This should change. Many clinicians are now going into public health.

1.3.5. Dr. Eva Hanciles – Anesthetist and President, Sierra Leone Medical and Dental Association

There were three physician anesthetists, four nurse anesthetists, three anesthetist assistants in Freetown during the civil war.

In 2001, Dr. Eric Reed helped to train 12 nurse anesthetists over a period of eighteen months. In 2006, UNFPA through the national anesthetic training program trained 100 nurse anesthetists (80 are practicing now) and 20 technicians (10 are practicing now).

As a means of strengthening training for nurse anesthetists and technicians: anesthesia personnel should be included in the scheme of service. Perioperative operative training programs should be instituted. Effective procurement strategies should be implemented. There should be regular continued professional development, for example, through exchange diploma programs in anesthesia in South Africa for 18 months, two-year training for nursing and four years of fellowship

for doctors in Ghana. Doctors could be encouraged with incentives to enter the West African College of Surgeons diploma program in anesthesia. There also needs to be adequate provision for anesthetic facilities in hospitals and additional attention to satisfaction for patient care.

Comment from the Chief Nursing and Midwifery Officer, Matron Hossinatu Kanu: The scheme of service for nurses needs to be modified to define clear career development pathways and progressions. The HRMO needs to recruit one consultant to help with employment.

1.3.6. Dr. Bundu Kamara – Chairman Health Service Commission

The Health Service Commission (HSC) was established by a constitutional provision. . It has a number of important responsibilities, such as helping ensure that training institutions conduct training to the highest standards and recruiting health professionals. However, there are a number of constraints. The management of the health workers is not within the mandate of the HSC and the scheme of service has many gaps and inadequacies.

1.3.7. Dr. Clifford Kamara

Basic health care should be considered as a human right. There is a need to transition from hospital care to primary health care. Community health workers or volunteer health workers need to be rolled out. Do not wait, do not rush. Prioritize and set short, medium and long term goals that are sustainable.

1.4. Perspectives from other developing countries: Liberia, Rwanda, Ethiopia, Zambia, Ghana and Malawi

1.4.1. Moderator: Dr. Francis Omaswa, African Centre for Global Health and Social Transformation (ACHEST)

He opened the session by presenting some of the global events supporting human resources. He referred to the Global Health Workforce Alliance (GHWA) Country Coordination Facility structure which was established in a number of countries. He explained that WHO recently developed a WHO Health Workforce 2030 strategy endorsed by the World Health Assembly. Country case studies were then presented by panel members.

1.4.2. Dr. Stephen Rulisa, University of Rwanda

The story in Rwanda started 22 years ago after the genocide. There was an opportunity to do things differently. The government took control over the use of external funds. The government was therefore able to avoid parallel spending, high overheads and programming not aligned with its national plan. This enabled the country to increase the workforce with a focus on shifting to higher skill levels. The drivers of health successes were attributed to: 1) political will; 2) a strong accountability system at each decision making level; and 3) the promotion of home grown and context-specific solutions to their problems.

1.4.3. Dr. James Beyan, Ministry of Health, Liberia

During the Ebola outbreak, health workers were at a much higher risk of catching the virus and there was a lack of adequate occupational health and safety to protect the workforce. Moreover, many were not on the government payroll. Coupled with low pay, this led to high health worker attrition and strikes. In the new investment plan of 2015-2021 for building a resilient health system, the development of a 'fit for purpose and productive workforce' was given the highest priority. The Health Workforce Program to deliver this includes strengthening health workforce education, implementing a national health workforce program and ensuring longer-term workforce planning is

needs-based. Systems for getting staff onto the payroll were streamlined and the percentage of staff not on the payroll has been reduced from 44% to 37% between April 2015 and February 2016. Overall about 4,000 health workers are expected to be absorbed as part of the Emergency Hiring and Management Plan 2015. Training capacity and government funding for expanding the health workforce remain challenging.

1.4.4. Dr. Getachew Tollera, Ministry of Health, Ethiopia

The Health Sector Transformation Plan (HSTP) has three primary objectives: Ensuring Equity and Quality, Universal Health Coverage and Transformation. To support this, the National HRH strategy has the vision of having an adequate number of well-qualified, committed, compassionate, respectful and caring health workers. The use of task-shifting through the employment of 39,000 Health Extension Workers working at the primary level is a flagship program supporting the national HRH strategy. The 204,000 public sector health workers enjoy a number of benefits to keep them motivated including free tuition and being two steps higher on the civil service pay levels. Leadership and accountability for successful implementation are critical. The presenter also highlighted the importance of good coordination by using one plan, one budget and one report.

1.4.5. Dr. Roy Chihinga and Manase Chipako, Ministry of Health, Zambia

Zambia started health reforms in 1991 which included decentralization. A Central Board of Health (CBoH) was created and districts became autonomous health boards. The high cost of the CBoH and the lack of technical expertise at provincial level contributed to a recent recentralization. In 2011 the primary health function was moved to a new ministry, but consolidation into one ministry again occurred in 2015. The ministry has been experimenting with the development of new cadres to cope with staffing needs. Regulation is simplified by having only two professional councils - one for nurses and midwives and a Health Professionals Council for all other health professionals including doctors. There is an overall shortage of 38% of health workers against public sector health positions. One way of alleviating the problem of shortage has been to speed up the process filling vacant posts. By delegating powers to the permanent secretary in the Ministry of Health, provisional letters of appointment can be provided within one week. The appraisal system is being reviewed to facilitate better dialogue. A lesson shared was the importance of planning a good change management process, including labor unions, to bring staff on board to implement reforms.

1.4.6. Dr. Hilario Chimota, Ministry of Health, Malawi

Malawi declared its situation a health workforce crisis in 1997. In 1999 the Government came up with a five-year development plan. However, the Emergency Human Resource program of 2004-7 accelerated progress with, amongst other strategies, donor-funded salary top-ups and short-term international recruitments. Staffing increases in the public sector were also achieved by streamlining the registration process for new graduates who had otherwise been lost because of delays. Salary top-ups can be contentious due to the difficulty of getting sustained national funding. Lessons shared included: 1) an emergency response may be a way of galvanizing action, 2) external support using international volunteers is an important a stop-gap measure, and 3) increases in staffing numbers must be accompanied by improvements in Human Resource Management to ensure a good return on the investment.

1.4.7. Dr. Kwesi Asabir, Ministry of Health, Ghana

At the beginning of the current HRH planning period (2002-16) Ghana had a major problem of staff shortages. Training outputs have significantly increased; for example, medical officers increased from 310 in 2011 to 520 in 2015. Another strategy for making the existing workforce more productive was to use task shifting. Professional migration has long been a problem, but the MoH was able to make a political case to increase salaries. There are now so many school graduates

applying to medical school because a good "enabling environment" has been created. Because of the increased demand on medical school places, many students go abroad for medical training but return to work in Ghana. A key lesson is to develop immediate, short, medium and long term plans and programs to obtain an adequate number of HRH.

The following issues surfaced during the question and answer session. The importance of home-grown solutions (don't use "copy and paste" solutions) is critical. You can start small with post-graduate training using specialists in the country, but itshould be competency-based and not all in the classroom. When trying to reduce delays in human resource management processes, it helps to use a business process analysis (mapping the systems) to identify areas of delay.

2. Proceedings for day 2: June 3rd 2016

2.1. Recap of previous day

2.1.1. Historical and current challenges to HRH in Sierra Leone

Access to healthcare is a fundamental right of Sierra Leoneans and strengthening HRH is a critical part of the Government's commitment to this right. Health worker shortages remain a persistent challenge for Sierra Leone and, at current rates of production, the Government will not meet facility-based targets in the Basic Package of Essential Health Services.

2.1.2. Lessons from other countries

There were some key lessons from other countries, including the importance of **buy-in, communication, and involvement** with “change management plans” to maintain momentum. The significance of **political will, strong leadership, accountability** to maintain momentum and reach goals. A Strategic Policy must include **sustainability** as a guiding principle and be highly consultative in its approach; Inter-sectoral engagement key for effective planning. As one participant advised the day before, one should consider to “Plan long and review short—this job will never be finished”.

2.2. Technical Discussion 2 (Plenary Session): Recruitment and Workforce Financing

Moderator: Mr. Andrew Sorie, Director of Recruitment and Workforce Financing, HRMO

2.2.1. Dr. Tim Martineau, Liverpool School of Tropical Medicine/ReBUILD Consortium

The recruitment to retention pipeline is central to understand and apply. This model highlights the importance of understanding secondary school dynamics and reinforces the importance of looking at health training across the health sector (selection criteria and process) as well as other training. Gender is a hugely underappreciated topic and is related to human resource planning and management needs to be discussed in a summit like this. Registration on payroll, initial posting is critical. He highlighted workforce financing reforms to improve negotiation strategies on wage bills. It is important to understand budget cycle, be guided by labor intensive conditions (for salary premium), manage health worker expectations and industrial relations.

2.2.2. Dr. Stephen Rulisa, Dean of Medical School Rwanda

Rwanda has a population of 12 million people with a life expectancy of 62 years with 45,000 health care workers. There has been a change in the health system, with the medical school now enrolling 165-200 students per year. A post graduate medical program was started in 1998 at the faculty of medicine. Yet challenges remain. There is a lack of coordination between the Ministry of Health and the Ministry of Education, shortage of local facility and difficulties with the retention of skilled health workers.

Comments from the panel

- **Mr. M.R. Koroma, Secretary to the Health Service Commission:** Sierra Leone’s recruitment policy is not well defined. This is sometimes influenced by political factors. Budget is not properly allotted and this leads to financial distress. Donor support is not demand-driven.

- **Matron Hossinatu Kanu, Chief Nursing and Midwifery Officer:** The recruitment process is cumbersome and is not well coordinated. There is no functional system for individual performance appraisal. There is a lack of a remote allowance. There is political influence on posting. Job descriptions are generic and are not adapted for the appropriate cadres. Volunteer staff remains an issue to be discussed.

Discussion/Responses from the Audience

- **Mr. Andrew Sorie, Director of Recruitment and Workforce Financing (HRMO):** The civil service code states that it is unacceptable to use the service of an individual who is not on salary. The delay in recruitment is sometimes the result of the fact that staff are posted but report to their posts untimely. Other times, foreign documents are cross checked with the issuing institutions which can also cause delays.

- **Prof. George Gage, Coordinator, 6-9 Months Plan (MoHS):** The health workforce is complex to manage because different people have different skills, attitude, motivation and behavior. Administrators and teachers of training institutions should be involved in planning the human resource for health. Attrition rate is high among doctors from COMAHS.

- **Dr. Brima Kargbo, Chief Medical Officer (MoHS):** 43 doctors graduated from COMAHS last academic year and the post graduate training program is underway. The MoHS has committed its support to training.

- **Mrs. Safiatu A. Foday, President, Midwives Association:** There is need to motivate healthcare workers posted to hard-to-reach areas.

- **Dr. S.A.S Kargbo Director, Health Systems Planning, Policy & Information (MoHS):** Targets should be set. For the production of health care workers, demand should meet the supply.

2.3. Technical Discussion 1 and 3 (Breakout Sessions): Pre-Service and In-Service Training and Performance Management, Motivation and Regulation

2.3.1. Group 1- Medical Officers, Moderator- Dr. Arthur Williams

I. How can pre-service training be best coordinated amongst MoHS, MEST and the private sector?

- At present COMAHS (College of Medicine and Allied Health Sciences) and the Ministry of Education are responsible for pre-service training of doctors. COMAHS opened in 1988. The 6-year medical course is preceded by two years pre-medical training which is designed to ensure students have an adequate grounding in the basic sciences before commencing their clinical studies. Students who achieved B grade and above in A-levels can bypass the pre-medical years. West African Secondary School Certificate Exam (WASSCE) students can bypass pre-med year 1 if they have 4 credits or better. Minimum entry requirements for Premed are 5 WASSCE credits.
- There is a high attrition rate of candidates in the first 3 years, partially because of failure to meet exam requirements and partially because a proportion of the initial intake are expected to go into Pharmacy. In order to conserve resources, an entrance exam was suggested to screen out students who would not be capable of progressing through medical school. The WASSCE was considered to be a poor discriminator of ability.

- Dr. Stephen Rulisa of Rwanda reported that they found that secondary school grades were a poor predictor of who would do well in medical school.
- An area identified for improvement was the number of teaching staff. (Despite rigorous exams, students are largely self-taught and constrained by limited teaching resources.)
- Increasing applicants to medical school may lead to a reduction in the quality of candidates, and the group discussed improving provision of basic sciences at secondary school to increase students capable of applying. Extra incentives for secondary school science teachers were suggested. In the past Sri Lankan and Indian teachers were brought to Sierra Leone to supplement science teaching.
- Medical school costs are a barrier to some students. International students tend to pay their own fees, whilst the majority of students have a government grant. It was suggested that weak academic students are able to succeed because of their family's wealth, whilst some more able students are lost due to an inability to pay. Dr Stephen Rulisa explained Rwanda has moved from a system of universal government grants for medical students to only giving loans. These, he explained act as an incentive and a retention strategy. It is in the government's interests to employ the doctors, and it is in the doctors' interests to take a Rwandan job, because the loans must be paid back. He also said that Rwanda does take international students as their fees help with funding studies. Dr. Emmanuel Ugwa of Nigeria and working for Jhpiego said that in Nigeria they also train international students, and they offer bursaries in some states to enable poorer students to attend medical school.
- The low numbers of teachers available is a challenge. There is a lack of specialists in all areas and new young doctors are providing some of the teaching. Efforts should be made to encourage older, more senior doctors to come back to teach within in-service training.
- A lack of payment is a constraint in encouraging doctors to contribute to teaching, but it was noted that Sierra Leonean doctors should be providing the training instead of internationals, as they understand the system of the health system more thoroughly.
- It was noted that log-books to support training exist at the pre-clinical and in-service House Officer level, but that these needs to be implemented and evaluated more thoroughly.
- There was discussion about the best length of training for House Officers. It used to be one year in Sierra Leone, and is currently two years to enable greater skill acquisition. The group heard about the one year of National Service that follows the housemanship in Nigeria, and Ethiopia which allows those who have already completed an undergraduate degree to become doctors in 4 years rather than 5 or 6.

II. How can in-service training be delivered in a coordinated and productive way across programs by government/NGOs?

- Harmonization of training manuals and protocols was identified as a priority.
- Dr. Zufan Abera, Director of theHealth Extension Directorate, Ministry of Health Ethiopia said that their Ministry has to approve all guidelines and training manuals and that credits are awarded for training, with the number of credits being proportional to the need for that skill within the health system.
- Continuous Professional Development programs, accredited by MoHS and associated with credits were suggested.

The Rwandan representative advised that the government should own all in-service training and NGOs should be implementing only what the government has approved.

2.3.2. *Group 2- Nurses and Midwives, Moderator: Matron Hossinatu Kanu, Chief Nursing and Midwifery Officer, MoHS*

I. Pre-Service and In-Service Training options are strong but inconsistent

- Of eleven training institutions, only five are government owned schools; the rest are FBOs or NGOs.
- Two additional training institutions are meant to open in the coming year.

II. Production of nurses, midwives, and related cadres does not match the need

- The degrees offered and numbers of produced health workers do not match need – this is supported anecdotally and by the recent payroll analysis.

III. Quality control at training institutions is non-existent; increasing entry-requirements might help improve the quality of incoming students

- To become a State Registered Nurse (SRN), students currently need to pass an introductory examination and enter with ~5 credits worth of courses; soon, additional English requirement will be added.
- Nestor Mayo of the ICN asked "how else can we improve the quality of the students? What role can regulation play in improving the overall quality and standard of health workers?"

IV. Training institutions require stronger accreditation

- A process and framework for accreditation have recently been developed by the CNMO's office.
- The Nursing and Midwifery Board can deploy the accreditation tool but there is little ability to enforce it; only the MoHS has the mandate to close schools, and this must be done in coordination with the Ministry of Justice. Similar issues exist for licensure of individual health workers.

V. Licensure for some nurse/midwife cadres exists but needs strengthening

- For State Registered Nurses, graduation is followed by a state board examination and supervised training; successful applicants are officially registered and issued a license to practice; these licenses are meant to be renewed every three years but, practically speaking, there is no enforcement of this rule.
- Centralized licensure process presents a challenge for individuals in the districts; no accountability or incentive mechanism exists to promote re-licensure – currently, it is an honor system (in some cases, matrons at hospitals will encourage their staff to re-license).

2.3.3. *Group 3 - Allied Health Professionals, Moderator - Mr. Abu Conteh, Chief Community Health Officer*

I. Regulatory

- Unlike Ghana or Uganda, Sierra Leone currently has no regulatory body for allied health professionals. Two approaches to regulation were discussed; i) the Zambia model: each and every Allied Sciences has its own regulatory board that works in concurrence with

the one, and ii) The Ghana Model: there is one main Allied Sciences regulatory body which oversees all activities of Allied Science professionals in country.

- It was requested that a technical regulatory body is formed to serve as an interim to regulate Allied Health professionals. This committee will work on the formation of a regulatory body.

II. Pre-service Training

- Accreditation of training institutions remains a challenge. Members expressed that for quality to be assured; the process of accreditation should be adhered to for specific cadres in all training institutions and must be monitored by the Ministry of Health and Sanitation as a whole. The entry requirement enhances quality output and aid in getting fewer students for effective supervision.
- No training should commence without accreditation.
- Entry qualification should be clarified and standardized.
- Proper coordination should exist between the Ministry of Health and Sanitation, Ministry of education Science and Technology and the Technical Education Committee.
- Every training should be in the Scheme of Service to verify Career Path.

III. In-service Training

- It was maintained that most in-service training in country is disaggregated, and needing more effective coordination
- There should be an in-service training framework which will ensure continuous or professional training in country
- A taskforce should be established to coordinate and oversee all in-service training for quality assurance. Proper monitoring and supervision should be carried out by the taskforce.

2.3.4. Group 4- Pharmacy Professionals, Moderator - Mr. James Komeh Deputy Registrar, Pharmacy Board

I. Restructuring the regulatory board

- There was group consensus that there should ideally be two pharmacy boards: one to regulate personnel, and one to regulate products.
- Current regulatory emphasis is on product which leaves little time for equally pressing personnel regulatory issues.

II. Clarifying process of obtaining membership with the Pharmacy Board after gaining membership in the Pharmacy Society

- The current system as established by the parliamentary act requires pharmacists to have membership with the Society before being eligible for admission to the Board.
- The group agreed that, ideally, the Board would be able to serve as the Society for performance reports on pharmacists applying for licenses or for license renewal.
- In reality, personnel management and performance monitoring by the Society is limited, meaning that pharmacists automatically become eligible for Board licensing regardless of professional performance during their one-year internship.
- One potential solution discussed was to form a special committee with members from both bodies to discuss how to improve the Society’s oversight of its members so that this information can be leveraged by the Board.

- The society is currently working to improve their personnel file management system, and wants to work with the Board to create a personnel database.

III. Strengthening pharmacist training programs

- Accreditation
    - The board has the authority to accredit training programs; the only current program is at COMAHS.
    - The Board submitted accreditation policy document to the Faculty at COMAHS 2 years ago but never received feedback.; The board needs to check on the review of this document to see how process can be moved along.
- Pre-service training
    - MoHS has the mandate to train pharmacists, but there is a disconnect with the COMAHS faculty which results in poor coordination of training needs with implementation.
    - Both the Society and the Board want improved leadership within MoHS so that precise training needs are articulated to the faculty.
    - Medium-term and long-term plans should include expansion of pharmacy programs to other training institutions. A gap will be created by aging senior pharmacists leaving the workforce.
    - Short-term PST plan should start by increasing the number of pharmacy educators who can teach at COMAHS because the current program could accommodate more students with more lecturers.
- In-service training
    - Many in-service training opportunities exist for Pharmacists, but they are often poorly publicized by the private organizations in charge.
    - Information sharing should be increased so that all pharmacists are made aware of the in-service training opportunities available to them.

IV. Continuous Professional Development

- As established by the pharmacy board parliamentary act, annual continuous professional development (CPD) is required in order to qualify for license renewal.
- Implementation of CPD is poor, so currently pharmacists only need to show up for the CPD trainings in order to satisfy the requirement.
- CPD implementation should be improved so that good performance is required to satisfy CPD requirements (i.e. testing pharmacists on what they learned during CPD in order for them to get credit).

2.3.5. Group 5- Community Health Workers, Moderator- Dr. J.N Kandeh, Director, Primary Health Care (MoHS)

I. Status and structure of program

- There CHW strategy and policy are almost complete, as are the training manuals. The program is to be rolled out in September.
- Remuneration is covered for 5 years by partners.
- Absorption into the health workforce is the vision.

II. Training

- MOHS has defined national curriculum to ensure training is consistent nationally.
- In order to facilitate a connection with the formal health system and ensure clinical oversight of the CHW training, MOHS health staff will be involved in training CHWs in the revised training package. This will include national MoHS staff as Master Trainers and DHMT staff, including Chiefdom Supervisors (CHOs) and some PHU in-charges, involved in training CHWs within districts. However, the National CHW Hub is considering the possibility of also using external trainers in order to facilitate a faster national roll-out and to reduce the burden on the existing health staff.
- There needs to be a solution that meets immediate needs but expands scope of services; Sierra Leone cannot copy the two-year training in Rwanda, for example, but must be more comprehensive than the current 10 day training.
- MoHS HR Directorate needs to be involved in coordination.

III. Monitoring and supervision

- Peer supervisors to reduce burden on health workers, facility management committees and PHU staff.
- Is there an opportunity to decentralize monitoring and regulation to local governments?

2.4. Special Lunch Session by Mr. George Werner, Minister of Education, Liberia, Co-Chair Inter-Ministerial Task Force on Health Workforce, Member of UN Commission on Health Employment and Economic Growth with Dr. Tana Wuliji.

The Sustainable Development Goals (SDGs) set an ambitious agenda to improve the lives of all, including through improved health and prosperity. Recent outbreaks have additionally confirmed the urgency of building resilient health systems and strengthening global health security. Health workers and health employment reside at the heart of the SDG agenda.

The global economy is projected to create around 40 million new health sector jobs by 2030; mostly in middle- and high- income countries. Despite the anticipated growth in jobs there will be a projected shortage of 18 million health workers to achieve the Sustainable Development Goals in low- and lower-middle income countries.

The rising global demand and need for health workers, over the next fifteen years, presents significant challenges. Importantly, it also offers the opportunity to generate employment, in areas where decent jobs are most needed.

The Commission is charged with proposing actions to guide the creation of health and social sector jobs as a means to advance inclusive economic growth, paying specific consideration to the needs of low and middle income countries. The Commission will present multi-sectoral responses to ensure that investments in health employment generate benefits across the SDGs.

In brief, the Commission seeks to:

- Recommend multi-sector responses and institutional reforms to develop over the next 15 years health human resources capacity for achieving SDGs and progress towards Universal Health Coverage (UHC). These actions will enable inclusive economic growth by creating a sustainable local source of employment.
- Determine innovative sources of financing and the conditions needed to maximize socio-economic returns from investments in health and social sector employment.

- Analyse the risks of global and regional imbalances and unequal distribution of health workers and assess the potential beneficial and adverse effects of international mobility.
- Generate the political commitment from government and key partners necessary to support the implementation of the Commission's proposed actions.

The Commission is a strategic political initiative that complements broader initiatives, developed by international agencies and global health partners, and brings together a balance of policy, technical and geographical expertise from the education, employment, health, labour and foreign affairs sectors of government; alongside international organizations, health professional associations, trade unions, academia and civil society.

2.5. Input from Health Development Partners

Key Question: ***How do the program priorities and funding of the HDPs match up with the discussions of the previous two days?***

This session was chaired by Dr. Sarian Kamara, Deputy Chief Medical Officer I at the MoHS. She started by asking the panel what they see as the key priorities and challenges.

- **Sally Taylor from DFID** said they had been supporting the government to think about how to prioritise resources to achieve the maximum impact in health. They have helped government around accountability and the use of resources e.g. better management of the payroll. DFID hopes to continue to support the government in these areas.

- **Parminder Brar from the World Bank** suggested it was important to start with the bigger picture before looking at HRH. For example, the Public Service Commission had not been included in the programme. His second point related to the wage bill. Sierra Leone's tax to GDP ratio is 9.6% and the payroll accounts for about 70%, so there is not much flexibility for increasing the payroll in any sector, not just the health sector. He asked what lessons there were from the past. For example, there has been a huge increase in the workforce, from 7,000 to 10,000 under the Free Health Care Initiative and the wages of doctors and nurses increased dramatically. He asked whether six years later this has really made a difference to health in Sierra Leone. In 2009 the government had a pay reform strategy and health was only sector which deviated from reforms. This derailed the pay reforms, as every other sector wanted pay increases, too. The consequences of this should be kept in mind when developing the strategy. He also argued that the health sector is highly fractured and we need better information on who is being funded by whom and at what rates. The World Bank is supporting the strengthening of systems and capacity by bringing in medical staff from other countries. The Bank will also be supporting 5,000 CHWs in hard to reach areas.

- **Anders Nordstrom from WHO** started by invoking the WHO World Health Report of 2006 on Human Resources for Health. This changed global thinking on HRH. On the ground here in Sierra Leone, WHO is engaged in health systems strengthening - including the critical area of HRH. This conference is a useful step for moving forward. WHO has also supported work on Ebola - with other partners providing on the job training and coaching. Now Sierra Leone has a more impressive workforce. WHO's future support will focus on institutionalizing HRIS, the strategic planning process and addressing coordination challenges forin-service training (IST).

- **Tej Nuthulaganti from CHAI** explained that CHAI is supporting various governments through policy and strategy development and are helping to bring together experiences from other African countries, for example through deep engagement in HRH strategy and implementation in both Liberia and Sierra Leone. CHAI is currently providing technical assistance to the HR

Directorate as well as the Directorate of Nursing Services of MoHS, supporting strategy development, overall strengthening of workforce management systems, implementation of plans, and the activities of various working groups.

- **Geoff Wiffin from UNICEF** shared that something important coming out of this meeting is the recognition that HRH is central to achieving the 10-24 month plan objectives. The role of CHWs during the Ebola crisis was critical. The opportunity through financial support from World Bank and the Global Fund for 11,500 CHWs provides new opportunities. However, it is vital to ensure CHWs are in the hardest to reach areas. UNICEF will continue providing TA for training, setting national standards and supporting implementation.

- **Rajeev Vishwakarma from VSO** shared their work supporting health worker induction and training. VSO has also conducted situation analyses on health worker stress in maternal health care, and is looking at ways to manage this stress. VSO is thinking about information technology for continuous pregnancy monitoring and is considering how to leverage mobile technology. VSO is also looking to support literacy programs for CHWs.

2.6. Technical Discussion 4 (Plenary Session): Governance and decentralization

This session sought to provide responses to the following questions:

1. What is the process by which HRH decision-making should occur across the central and district levels, and what specific decisions can be decentralized? And what are recommendations to ensure that this process progresses?
2. What specific activities or responsibilities should be decentralized?

- ***Dr. Francis Omaswa of the African Centre for Global Health and Social Transformation (ACHEST):*** He introduced his presentation by situating the context of the topic, highlighting the disproportionate burden of diseases in Africa and some of the root causes of the health crisis in Africa including the high level of poverty, population growth, high dependency on external assistance, low ownership of development initiatives, etc.

  On the governance piece, Omaswa narrowed down the presentation to the four pillars of a national HRH program:

  - Multi-sector Country Partnerships (GHWA CCF: Professionals, CSO, Politician, Private Sector)
  - Health Sector Strategic Plan (HSSP)
  - Comprehensive HRH Plan in line with HSSP (Tools)
  - HRH Information Systems (Observatories) with Annual Reporting and Response (Tools)

  He elaborated on the prioritization process for reinforcing governance in the health sector, highlighting the key processes; burden of disease study, services facility survey, resource envelop, health workforce information system, and development of partnerships. He also emphasized the need for quality assurance, linking this up with the critical factors for success and scale up which includes: political commitment and good governance, workforce planning and an enabling environment. He focused the second part of the presentation on decentralization with both positive and negative the lessons learnt from Uganda.

- **Dr. Zufan Abera, Ministry of Health Ethiopia:** He outlined the Ethiopia's decentralized health service delivery structures, good governance and some lessons learnt. With a population of over 92 million inhabitants, Ethiopia developed a Health Sector Transformation Plan (HSTP) which ran first from 2008-2012 and then from July 2015– June 2020 with the key objectives being to ensuring equity and quality, universal health coverage and transformation.

  The presentation showcased decentralization infrastructure in Ethiopia with a health system hierarchy from the health post which is the smallest unit in the Federal Ministry of Health. This approach empowers the government structures to lead and own their developments.

  On the governance piece, he highlighted the availability of compassionate, respectful and caring health professionals who provide special and targeted support to reduce the state of inequality in human power distribution.

  The presentation highlighted amongst others the need to ensure national ownership and most especially for the policies align with the strategy. The health structures should be decentralized but with close support and supervision through regular review meeting at all levels, integrated supportive supervision at all levels, HMIS and operational researches

- **Dr. Manase Chipako, Ministry of Health Zambia:** He underlined the fact that the MoH Zambia developed a Governance and Management Capacity Strengthening Plan which ran from 2012–2016, aimed at ensuring that there is accountability, transparency, efficiency, effectiveness and integrity in the use of public funds in health service delivery. The following governance systems have helped in the implementation of this plan:
  - Sector Wide Approach programme (SWAp)
  - Joint Annual Review meetings (JAR)
  - Policy meetings
  - Sector Advisory Group meetings (SAG)
  - Procurement committee
  - Finance Committee

  To further reinforce this, the MoH focused on leadership as the key to successful implementation of programs, signing MoUs with partners and delivering its services from community level to tertiary level of care through a referral system. Other components of the organizational management structures enhanced good governance include: leadership and governance, capacity building, policy and regulation, service delivery, procurement and supply chain, health care financing, financial management and audit, monitoring and evaluation.

  Regarding decentralization, the presentation pointed out the fact that the Government of Zambia launched a Public Service Reform Programme (PSRP) in November 1993, aimed at improving quality delivery, efficiency and effectiveness of public services to the people of Zambia. The MoH on its part developed the Sector Devolution Plan for Primary Health Care in line with the National Decentralisation Policy focusing on the transfer of authority, specific functions and resources from central government Ministries, Departments and Agencies to local authorities. This, alongwith a number of other policy decisions, helped in the transfer of authority to other ministries and structures such as local councils all of which have led to improvements in the overall health sector management.

The full presentations are available online and can be accessed through the following link:

Link to HRH Working Group Dropbox – HRH Summit 2-3 June Folder

2.7. Meeting Recap: Recommendations for Sierra Leone

Before concluding the summit, the Director of HR, Samuel Coker, briefly summarized key points and next steps. The summit laid the foundation for the development of a refreshed HRH policy and a new HRH strategic plan for the next five years. Starting early July, the MoHS will convene thematic technical committees to address challenges raised at the summit and create a unified vision within the health sector on how to have an effective, resilient and motivated health workforce serving the population. Through the work in the technical committees, the HRH policy written in 2012 will be updated and guide the strategic plan, which will serve as a clear road map for strengthening the workforce, including goals, measurable targets, prioritized and costed activities, and a monitoring and evaluation framework.

In addition to this, the directorate of HRH will continue to engage all stakeholders on the key management issues, such as interoperability of HRH information systems, evidence-based decision making, the payroll integrity and a strengthening of district level HRH.

2.8. Closing Remarks / Vote of Thanks

The summit was concluded by Dr. Sarian Kamara, Deputy Chief Medical Officer I, MoHS. She thanked all participants for the fruitful discussions over the past two days, launching Sierra Leone’s strategic planning process for HRH. She highlighted that the high spirits and committed engagement demonstrated a collective willingness to improve the current workforce figures and health outcomes.

On behalf of the Honorable Minister of Health and Sanitation, Dr. Kamara thanked representatives from Ministry of Education, Science and Technology, Ministry of Local Government and Rural Development, Ministry of Finance and Economic Development and Ministry of Foreign Affairs and Development Partners. She extended a special thanks to the Minister of Education and the Ministry of Health Assistant Minister of Planning from Liberia, and also expressed the Ministry’s gratitude to the international guests from Ghana, Rwanda, Ethiopia, Zambia, Malawi and Liberia. Further, Dr. Kamara expressed the MoHS’s deepest thanks to WHO and CHAI for co-sponsoring this event with MoHS. On behalf of the ministry, she also thanked all of the presenters, panelists and participants for the valuable perspectives and contributions.

Dr. Kamara continued by emphasizing that, as the Honorable Minister discussed at the opening remarks of this meeting, Sierra Leone’s health workforce is a top priority of the government. She noted that it will take a team effort of governments, agencies and commissions alongside development partners to make the necessary improvements that Sierra Leone needs. This is the beginning of a journey to improve the health system broadly but especially on human resources for health, which is the cornerstone for any improvements within the health sector.

2.9. Annexes

2.9.1. Annex 1: List of participants

	ATTENDANCE REGISTER HRH SUMMIT (June 2-3, 2016)		
S/n	**Name**	**Title**	**Organization/Institution**
1	Dr. Abu Bakarr Fofanah	Minister of Health and Sanitation	MoHS
2	Maya Kaikai	Minister of Local Government and Rural Development	MLGRD
3	Elizabeth H Ellie	Permanent Secretary/ASP	Office of the President
4	Sherley O Luke	HR Officer	Office of the Vice President
5	LI Jian Dony	Secretary	Chinese Embassy
6	Ebrima N A Camara	Secretary	The Gambia Embassy
7	Ali Asghar Moghari	First Secretary	Iranian Embassy
8	H.E Nidal Yehya	Ambassador	Lebanese Embassy
9	H.E Leonel Lazo Montalvo	Ambassador	Cuban Embassy
10	Dr. Brima Kargbo	Chief Medical Officer	MoHS
11	David W S Banya	Permanent Secretary	MoHS
12	Dr. Sarian Kamara	Deputy Chief Medical Officer I	MoHS
13	Dr. Amara Jambai	Deputy Chief Medical Officer II	MoHS
14	Hossinatu Kanu	Chief Nursing and Midwifery Officer	MoHS
15	Fatmata Mansaray	Deputy CNMO	MoHS
16	Samuel Coker	Director, Human Resources	MoHS
17	Dr. SAS Kargbo	Director, Health Systems Planning, Policy & Information	MoHS
18	Aminata Shamit Koroma	Director, Food and Nutrition	MoHS
19	Dr. J. N. Kandeh	Director, Primary Health Care	MoHS
20	Dr. Victor Matt-Lebbie	Director, Hospitals & Laboratory Services	MoHS
21	Mr Bassie S.R Turay	Director, Drugs and Medical Supplies	MoHS
22	Dr. Foday Dafae	Director, Disease Prevention & Control	MoHS
23	Dr. Santigie Sesay	Director, Reproductive & Child Health	MoHS
24	Dr. Ansumana Sillah	Director, Environmental Health & Sanitation	MoHS
25	Fatmata Russell	Directorate of Food and Nutrition	MoHS
26	Dr. A T Muana	Focal person	MoHS/Mental Health
27	Mr Mohamed Daboh	Director, Support Services	MoHS
28	Dr. Clifford Kamara	Focal point for health-State House/Health Coordinator	MoHS/PDT
29	Emile Koroma	HRH Manager	MoHS
30	Abu Conteh	Chief Community Health Officer	MoHS
31	Mohamed A.S Kamara	Deputy Chief CHO	MoHS
32	Dr. George Gage	6-9 Month Plan Coordinator	MoHS
33	Dr. Bundu Kamara	Chairman SLHSC	MoHS
34	MR Koroma	Secretary SLHSC	MoHS
35	Esther Sovula	HR Officer SLHSC	MoHS
36	Elizabeth Musa	Principal CHO	MoHS
37	Dr. Sulaiman Conteh	Program manager	MoHS
38	Dr. Osaio Kamara	DMO Bombali	MoHS
39	Dr. Rev T T Samba	DMO Western Area	MoHS
40	Dr. James Squire	DMO Kailahun	MoHS
41	Dr. A P Koroma	Medical Superintendent PCMH	MoHS

42	Dr. David Baion	Medical Superintendent Ola During Children's Hospital	MoHS
43	Allieu Bangura	Hopsital Secretary-ODCH	MoHS
44	Alhaji Zonokong	Hospital Secretary, Makeni Government Hospital	MoHS
45	Ibrahim Fodey Musa	Hospital Secretary, Connaught Hospital	MoHS
46	Tutu Sessie	Hospital Secretary, Connaught Hospital	MoHS
47	Dr. Eva Hanciles	Cons. ICU	MoHS
48	Dr. Effie Gooding	PGMT Coordinator	MoHS
49	Dr. Len Gordon-Harris	COMAHS/PGC	MoHS
50	Dr. Joan H. Shepherd	Principal, National School of Midwifery	MoHS
51	Francess Fornah	School of Midwifery, Makeni	MoHS-SOMM
52	Sellu Keifala	HR Officer / Data Manager	MoHS
53	Jonathan A. Kamara	PRO	MoHS
54	Kadrie Koroma	Deputy PRO	MoHS
55	Hawanatu Lamin	Secretary	MoHS
56	Yayah Conteh	PDLO/WLO	MoHS
57	Mohamed Kanu	P/Health consultant	MoHS
58	Alhassan Kanu	Coordinator	MoHS/DPPI
59	John Conteh	HR Officer	MoHS
60	Florence Tucker	Higher Executive Officer	MoHS
61	Magdaleine Keitamo	Admin Officer, HRH	MoHS
62	Minkail Idriss Njai	Executive Assistant	MoHS
63	Dr. Alie H. Wurie	Senior Specialist	MoHS
64	Umaru Conteh	CHO	MoHS
65	Samuella S. Mahoi	HR Officer	MoHS
66	Mamie Miatta Johnny	Department Secretary	MoHS
67	Mayo A. Lamine	MDR-TB FP	MoHS/NCCP
68	Alie Bayoh	Senior Records Officer, HRH	MoHS
69	Alimamy Conteh	Pharmacy Technician	MoHS
70	Murtada Sesay	President	Pharmaceutical Society of Sierra Leone
71	Michael Lalai	Pharmacist	Pharmacy Board Sierra Leone
72	Sitta Kamara	Regulatory Officer	Pharmacy Board Sierra Leone
73	Alemamy S. carter	Adm Officer	Pharmacy Board Sierra Leone
74	Henry E C Carber	Regulatory Officer	Pharmacy Board Sierra Leone
75	James P. Komeh	Dep Registrar	Pharmacy Board Sierra Leone
76	Josephus Sawyer	Project manager	Tertiary Education Committee
77	Senesie Margao	President	Nursing Association of SL
78	Hannah Coker	Registrar	Nurses Board
79	Dr. Arthur Williams	President	SL Medical and Dental Council
80	Dr. Samuel Koitell	Ag Head of Department	School of Community Health
81	Michael M. Koroma	CEO	St John of God School of Nursing
82	Dr. Joseph Edem-Hotah	HoD	COMAHS SL
83	Dr. Bockarie Vandy	Director of Nursing School, Eastern Polytechnic	Eastern Polytechnic
84	Dr. Max Sesay	Chairman of PSC	PSC
85	Patrick Conteh	MOS	MOFED
86	Georgina Kamara	Director of Budget and Planning	HRMO
87	Andrew Sorie	Director of Recruitment and Workforce Financing	HRMO
88	Rhoda Kargobai	Director of Training and Career	HRMO

		Development	
89	Musu M Gorvie	DD/MEST	MEST
90	Abu Bakarr Carew	Permanent Secretary	MTA
91	Unisa S. Sesay	HR Officer	MTA
92	Dr. Mohamed K. Mansarey	Deputy Director	MFAIC
93	Sidik Osman Mansaray	Protocol	MFAIC
94	Aruna Kargbo	Protocol	MFAIC
95	Saffea Gborie	Communications Officer	WHO
96	Elisabeth Vock	Obstetrician/gyneacologist (rep & Maternal Health)	WHO
97	Anders Nordstrom	WHO WR	WHO
98	Elaina Davis	Management Support	WHO
99	Margaret Phiri	MNH Advisor	WHO
100	Robert Marten	Technical Officer HSS	WHO
101	Nuhu Yaqub	CH Advisor	WHO
102	Adewale Akinjeji	Technical Officer HSS	WHO
103	Florence Baingana	MHPSS lead	WHO
104	Christian Lara	Technical Officer HSS	WHO
105	Sade Beckley-Lines	Communications Officer	WHO
106	Dan Gwinnell	Country Director	CHAI
107	Tej Nuthulaganti	Director, Global HRH	CHAI
108	Annika Marking	HRH Program Manager	CHAI
109	Robyn Churchill	Senior Advisor, Global HRH	CHAI
110	Donald Conteh	HRH Advisor	CHAI
111	Silvestre Ngwa	Senior Program Officer	CHAI
112	Christine Sesay	Deputy Country Director	CHAI
113	Katie Pannell	Analyst	CHAI
114	Samuel Parker	Coordinator, Global HRH	CHAI
115	Jasper Sembie	Operations Officer	CHAI
116	Libby Abbott	Technical Advisor	CHAI
117	Eleonora Genovese	Health Specialist	World Bank
118	Angela Spilsbury	Health Advisor	DFID
119	Dr. Amit Bhandari	Health Advisor	DFID
120	Dr. Nuzhat Rafique	Health Manager	UNICEF
121	Dr. Kebir Hassen	Health Specialist	UNICEF
122	Margaret James	Health Officer	UNICEF
123	Chie Yoshimi	Expert	JICA ISSV Project
124	Ufuoma Festus Omo-Obi	Country Director	Marie Stopes
125	Alusine Bangura	HR Manager	Marie Stopes
126	Margaret Mannah Macarthy	Country Midwife Advisor	UNFPA
127	Dr. Mohamed Elhassein	RH Advisor	UNFPA
128	Dr. Mohammed Abbas Conteh	Coordinator	ReBUILD-COMAHS
129	Haja Wurie	Researcher	ReBUILD
130	Rogers Amara	Researcher	ReBUILD
131	Danny Amenogy	Fiscal Agent	Global Fund
132	Bockarie Sesay	M&E advisor	Options
133	Patrick Howett	Doctor	Kings Partnerships SL
134	Richard Lowsby	EM Coordinator	Kings Partnerships SL
135	Dr. Marta Lado	ID Coordinator	Kings Partnerships SL
136	Dr. Aurentiu Stan	CD	JSI

137	Jessica Gregson	Charlie Goldsmith Associates	CGA
138	Katie Barron	CD	PIH
139	Cecilia English	Advisor	PIH
140	Samuel Randall	Local Consultant	IntraHealth
141	Michael Friedman	CEO	CDC
142	Bintu Jawara	Matron	Emergency Surgical Centre
143	Lizzi Marmont	PL Coordinator	HealthCo
144	Victor Lansana Gulama	District Coordinator	Health Alert
145	Charles Mambu	Director	Health for all Coalition
146	Betty Sam	STO	LSTM
147	Ms Marina Mdaihli	Country Director	GIZ
148	Rajeev Vishwakarma	Head of Programs/Ag CD	VSO
149	Jasmine Riley	Training Coordinator	IOM
150	William J Liu	Lead of China Lab	China CDC
151	Walters Carew	Executive Director	CHASL
152	Vandy B. Sonnah	Assistant Program Manager	CHASL
153	M.B Jalloh	CEO	Focus 1000
154	Alex Kallon	Monitor	Coalition
155	Thomas B. Vandy	Monitor	HFAC
156	Josephine Fodey	past F/P	HFAC
157	Safiatu A. Foday	President	Sierra Leone Midwives Association
158	Ansu Rashid Kalokoh	Secretary General	Sierra Leone Health Service workers' Union
159	Daniel van Leerdam	(Medical Doctor) International Coordinator	CapaCare
160	Francis S. Vandy	HR/Admin manager	CapaCare
161	Dr. Mathew J. Vandy	Program Manager	NEHP
162	Patrick Edwards	Optometrist	NEHP
163	Dr. Patrick Coker	Private Practitioner	Private practitioner
164	Mohameed H. Bango	M&E	Civil Society
165	Dr. S.J Smith	Program Manager Malaria	MoHS
166	Isha Daramy Kubie	Consultant midwife	Friends of national St. John of God
167	Sara Kallay	Reporter	Star TV
168	Ade Cambell	Senior Reporter	Awoko Newspaper
169	Joseph Stanley	Producer	SLBC.
170	Benjamin Thomas		
171	Dr. Mary Kamara	O+G	Johns Hopkins
172	Dr. Howard Nelson-Williams	Epidemiologist	Johns Hopkins
173	Mrs N.T Moyo	Senior Advisor	ICM
174	Tim Martineau	Senior Lecturer	Liverpool School of Tropical Medicine/ REBUILD
175	Benedict C. Harris	Assistant Minister in charge of Policy and planning	Ministry of Health Liberia
176	James M. Beyan	HRH Director	Ministry of Health Liberia
177	George K. Werner	Minister of Education, Liberia	Ministry of Education Liberia
178	Dr. Hilario Raul Chimota	Director of Human Resources Management and Development	Ministry of Health Malawi
179	Emmanuel Ugwa	OR Adviser	Jhpiego
180	Dr. Phelelo Marole	Regional PSEA	Jhpiego
181	Dr. Kwesi Asabir	Deputy Director, Human Resources for Health	Ministry of Health Ghana

182	Dr. Stephen Rulisa	Dean School of Medicine and Pharmacy	University of Rwanda
183	Zufan Abera	Director, Health Extension Directorate	Ministry of Health Ethiopia
184	Dr. Roy Chihinga	Chief Human Resources Development Officer	Ministry of Health Zambia
185	Dr. Manase Chipako	Senior HR Management Officer	Ministry of Health Zambia
186	Jose Rafi Morales	Chief Medical Officer	HRSA
187	Harold Phillips	Director	HRSA
188	Dr. Getachew Tollera	Director, Human Resource Development and Administration	Ministry of Health Ethiopia
189	Dr. Tana Wuliji	Technical Officer	WHO Headquarters Geneva
190	Dr. Francis Omaswa	African Centre for Global Health and Social Transformation (ACHEST)	

2.9.2. Annex 2: Timetable

Day One: Thursday, 2 June 2016			
Time	**Activity**	**Moderator**	**Presenter/Participants**
08:30 – 09:00	**Registration of Participants**		
09:00 – 10:30	**Opening and Ministerial Session: The Vision for Human Resources for Health in Sierra Leone** ● Introduction of the Chairperson of the session (The Permanent Secretary MoHS) by the Human Resource for Health Director MoHS ● Welcome Remarks and Prayers by the PS (10 minutes) ● Opening Statement from the Chief Medical Officer (CMO) Statement by the Secretary to the Cabinet and Head of the Civil Service ● Opening Statements (10 minutes each) from: 1) Ministry of Education, Science and Technology (MEST) 2) Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA) 3) Ministry of Local Government and Rural Development (MLGRD) 4) Ministry of Finance and Economic Development (MOFED) 5) Ministry of Foreign Affairs and International Cooperation (MFIC) 6) Minister of Education Liberia ● Keynote address and official opening statement by the Minister of Health and Sanitation (MoHS)	Permanent Secretary, MoHS	● MEST ● MSWGCA ● MLGRD ● MOFED ● MOHS
10:30 – 10:45	**Tea Break**		
10:45 – 12:15	**Roadmap and objectives for Sierra Leone's refreshed HRH Policy and Strategic Plan** ● What is the practical utility of this meeting, and what reforms and activities can participants reasonably expect to see coming out of the two days?	Chief Medical Officer, MoHS	● Samuel Coker, HR Director, MoHS ● Emile Koroma, HR Manager, MoHS ● Sellu Keifala, HR Officer, MoHS
12:15 – 13:15	**Lunch Break**		

13:15 – 14:30	**Setting the Scene: Learning from past HRH experience in Sierra Leone (before during and after the civil war)** ● Discussion with local experts	Anders Nordstrom, WHO WR	● Dr. Len Gordon-Harris (COMAHS) ● Dr. Bundu Kamara (HSC) ● Dr. Eva Hanciles (SLMDA) ● Dr. Effie Gooding (Postgrad Program - HSS Hub) ● Dr. Patrick Coker (Private practitioner) ● Dr. Joan H. Shepherd (Principal National School of Midwifery)
14:30 – 16:00	**Perspectives from other developing countries: Liberia, Rwanda, Ethiopia, Zambia, Ghana and Malawi** ● What are the areas in which other countries have experienced relevant HRH successes across a range of areas - management, production, regulation, financing?	Francis Omaswa, Executive Director, ACHEST	● **Liberia, MoH:** James Beyan and Benedict C. Harris ● **Ethiopia, MoH:** Zufan Abera and Getachew Tollera ● **Zambia, MoH:** Roy Chihinga and Manase Chipako ● **Malawi, MoH**: Hilario Raul Chimota ● **Ghana, MoH:** Kwesi Asabir
16:00-17:45	**Tea Break**		
17:45-17:55	**Closing remarks**	HR Director, MoHS	
17:55-18:00	**Close of the meeting day 1**		
18:00- 19:00	**Reception**		

Day Two: Friday, 3 June 2016			
Time	**Activity**	**Moderator**	**Presenter/Participants**
09:00 – 09:15	**Recap of previous day** ●Prayers and presentation of previous day	Deputy CMO II	N/A
09:15-10:00	**Technical Discussion 2 (Plenary Session)**: **Recruitment and Workforce Financing**	Andrew Sorie, Director of recruitment and workforce Financing, HRMO	**Tim Martineau (Liverpool School of Tropical Medicine/REBUILD)** **Stephen Rulisa (Dean School of Medicine and Pharmacy, University of Rwanda)** Respondents: ● **HRMO:** DG Bayoh ● **HSC:** MR Koroma ● **MOFED:** Ansu Tucker ● **Head of the Civil Service:** Ernest A.S. Surrur ● **PSC:** Dr. Max Sesay ● **CNMO:** Hossinatu Kanu
15mins	**Tea Break**		

10:15 – 12:00	**Technical Discussion 1 (Breakout Sessions): Pre-Service and In-Service Training** ● How can pre-service training be best coordinated amongst MoHS, MEST and the private sector in such a manner that the supply matches the demand? ● How can in-service training be delivered in a coordinated and productive way across MoHS programs by the gov't and NGO **Technical Discussion 3 (Breakout Sessions): Performance Management, Motivation and Regulation NOW COMBINED WITH TECHNICAL Session 1 on Pre-Service/ In-Service Training** ● What are best practices by which workers are licensed, regulated and monitored, and training institutions are accredited? How can pre-service training be best coordinated amongst MoHS, MEST and the private sector? How can in-service training be delivered in a coordinated and productive way across programs by gov't/NGOs?	HR Director, MoHS (opening remarks, and plenary facilitation)	● **Group 1: Medical Officers** ● **Group 2: Pharmacists and Pharmacy Techs** ● **Group 3: Nurses and Midwives** ● **Group 4: Allied Health Professionals (CHOs, CHAs, Labs, Environmental Health plus other professionals)** ● **Group 5: CHWs**
12:00-13:30	**Special Lunch Session** by George Werner, Minister of Education, Liberia, Co-Chair Inter-Ministerial Task Force on Health Workforce, Member of UN Commission on Health Employment and Economic Growth with Tana Wuliji		
13:30-14:45	**Input from Health Development Partners** ● How do the program priorities and funding of the HDPs match up with the discussions of the previous 2 days?	Deputy Chief Medical Officer I	● **DFID:** Sally Taylor, Country Head ● **WHO:** Anders Nordstrom, WR ● **World Bank**: Parminder Brar, Country Manager ● **UNICEF:** Geoff Wiffin, Country Representative ● **CHAI**: Tej Nuthulaganti, Director, Health workforce ● **VSO**: Rajeev Vishwakarma, Head of Programmes & Ag. Country Director
14:45-16:00	**Technical Discussion 4 (Plenary Session): Governance and decentralization** ● What is the process by which HRH decision-making should occur across the central and district levels, and what specific decisions can be decentralized? And what are recommendations to ensure that this process progresses? ● What specific activities or responsibilities should be decentralized, and to what level?	Tim Martineau, Liverpool School of Tropical Medicine and ReBUILD	**Francis Omaswa, the African Centre for Global Health and Social Transformation (ACHEST)** **Zufan Abera, Ministry of Health Ethiopia** **Manase Chipako, Ministry of Health Zambia**
15mins	**Tea Break**		

16:15-17:15	**Meeting Recap: Recommendations for Sierra Leone** ● What are the clear set of next steps that can be articulated to the participants?	HR Director	N/A
17:15-17:30	**Closing Remarks / Vote of Thanks**	Deputy Chief Medical Officer I	N/A

2.9.3. Annex 3: Roadmap and objectives for Sierra Leone's refreshed HRH Policy and Strategic Plan