Ministry of Health and Sanitation
Government of Sierra Leone

Human Resources for Health Strategy 2017-2021

Ministry of Health and Sanitation

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List of Acronyms and Abbreviations

BPEHS	Basic Package for Essential Health Services
CHA	Community Health Assistant
CHC	Community Health Centre
CHO	Community Health Officer
CHP	Community Health Post
CHW	Community Health Worker
CMO	Chief Medical Officer
CNMO	Chief Nursing and Midwifery Officer
DHMT	District Health Management Team
DHRH	Directorate of Human Resources for Health
GoSL	Government of Sierra Leone
HRH	Human Resources for Health
HRMO	Human Resource Management Office
HSC	Health Service Commission
iHRIS	Integrated Human Resource Information System
IPAS	Individual Performance Appraisal System
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCHP	Maternal and Child Health Post
MEST	Ministry of Education, Science and Technology
MoFED	Ministry of Finance and Economic Development
MoHS	Ministry of Health and Sanitation
NPHA	National Public Health Agency
PHU	Peripheral Health Unit
PRP	President's Recovery Priorities
PSC	Public Service Commission
SECHN	State-Enrolled Community Health Nurse
SLA	Service Level Agreement
SRN	State Registered Nurse
TBA	Traditional Birth Attendant
TEC	Tertiary Education Commission

Note: A currency exchange rate of USD 1 = SLL 7,200 has been assumed in this document.

Foreword

Health workers are a crucial pillar in a well-functioning resilient health system. The Ministry of Health and Sanitation is committed to promoting a resilient health workforce that will provide equitable, high quality health care to all Sierra Leoneans. This commitment is adequately captured in the Health Sector Recovery Plan 2015 -2020 and the Basic Package for Essential Health Services (2015).

The importance of strong human resources for health was demonstrated during the recent Ebola Virus Disease (EVD) outbreak from 2014 to 2015. Health workers across all cadres demonstrated bravery in combatting the outbreak, from the community health workers facilitating the dissemination of information and encouraging safe burial practices in their villages, to the medical staff in isolation units risking their lives to treat Ebola patients. Unfortunately, as a result of these commendable efforts, over 250 health workers lost their lives to Ebola, exacerbating the already critical shortage of skilled health workers.

To continue rebuilding and improving the health system in Sierra Leone, the importance of human resources for health must be reflected in policies across the health sector. The Ministry of Health and Sanitation has already made substantial progress in this area over the past year, including (i) cleaning the payroll of inactive workers, (ii) operationalizing a comprehensive human resources information system; (iii) developing a training programme for Clinical Assistants – a mid-level cadre that will support the public health sector with clinical services in areas where doctors are limited, and (iv) developing programmes to train specialist medical doctors in country. The Ministry has also made headway in developing a comprehensive community health worker policy and strategy to enhance the health workforce's ability to cover the hard-to-reach populations.

The launch of the Human Resources for Health Strategy for 2017-2021 will continue building on this progress by providing a roadmap through which the health workforce in Sierra Leone's health sector will be further strengthened. The plan will address the most critical human resource for health challenges, across multiple intervention areas including training, regulation, financing and management.

The high levels of engagement, willingness to collaborate, and strong sense of government ownership projected by all parties involved in the strategy development process has been encouraging. The Ministry of Health and Sanitation will put the same qualities into the implementation of the strategy, in order to have the right health worker in the right place at the right time. I look forward to the support of all parties, from donors to implementing partners and the private sector, in the implementation of the 2017-2020 Human Resources for Health Strategy.

Honourable Dr Abu Bakarr Fofanah
Minister of Health and Sanitation

Remarks

From the early conception of this strategy, we have stressed the importance that this will be an evidence-based and implementable plan that would allow both government and partners to understand the priority intervention areas in HRH and mobilise resources to address them accordingly.

The Human Resources for Health Strategy 2017-2021 has been developed in a series of technical committee meetings broken down by thematic area, including pre-service training, in-service training and regulation; financing and planning; and management and governance. As co-chair of the Steering Committee, I have overseen progress of the strategy's development and have witnessed collaborative discussion evolve into a structured, feasible and costed plan.

This document is thus a culmination of the input of a substantial group of national stakeholders, including ministries, departments and agencies across GoSL, numerous directorates and programmes of the Ministry of Health and Sanitation, the district health management teams, hospital leadership, training institutions, individual facility-based health workers, civil society groups, and the private sector, as well as international partners, NGOs and research institutions – in total amounting to over 260 individuals consulted throughout the process. I am grateful for the participation and dedication that these stakeholders have demonstrated. These inputs will help to guide interventions in HRH to strengthen the Sierra Leone health workforce over the next five years.

Dr. Brima Kargbo (GOOR)
Chief Medical Officer
Ministry of Health and Sanitation

1. Executive Summary

Human Resources for Health are a crucial component in delivering high quality, affordable, and accessible health care services in every country. The ability for a country to meet its health goals depends largely on the knowledge, skills, motivation, and deployment of the people responsible for organising and delivering health care services. In the last few years, increasing attention has been paid to the development of health policies that guarantee better health outcomes in many countries. However, a major drawback of these health policies has been their failure to address Human Resources for Health.

In Sierra Leone, persistent gaps in human resource capacity exist across all cadres, districts, and health care levels within its public-sector health workforce. These insufficient staffing levels have long been recognised as a key barrier to a resilient and responsive health system. The gap between staff needed and staff practicing has historically been most critical in higher cadres – particularly doctors and midwives. However, since the introduction of the Free Health Care Initiative in 2010, the health workforce has grown significantly – effectively doubling by 2011 (Oxford Policy Management, 2015). This positive trend was, however, interrupted by the recent Ebola crisis which claimed the lives of at least 257 health workers in Sierra Leone and caused many others to temporarily leave the workforce.[1] Though the health workforce has been growing overall recently, a significant number of the health workers are nearing the national retirement age of 60. Approximately 24% of all health workers are currently over the age of 50, while 394 health workers are already over 60.

The Government of Sierra Leone (GoSL) currently employs 9,910 health workers nationwide.[2] This number includes all administrative and support staff, with 7,107 (72%) health professionals providing patient services.[3] As of 2016, the government health workforce was distributed across 1,323 work stations, including hospitals, PHUs, clinics and administrative offices. Most health services are provided by public-sector health workers and very little data exists on the private-sector workforce (Ministry of Health and Sanitation, 2013).

The Directorate of Human Resources for Health (DHRH) led a highly consultative exercise to develop a national HRH Strategy to address these challenges affecting healthcare workers in Sierra Leone. It was conducted through three technical committees organised around different thematic areas. They were convened to review evidence on the status of the health workforce and develop activities to address

[1] *Directorate for Human Resources for Health, MoHS*

[2] *This number excludes health workers removed from payroll as a result of the 2016 MoHS payroll audit and health workers granted early retirement from the civil service in June 2016. The number includes a small number of active health workers employed by other ministries than MoHS.*

[3] *Classification of health professionals as defined by the International Standard Classification of Occupations (ISCO); does not include Nursing Aide, Support Staff, or Administrative Staff cadres.*

priority challenges in the immediate, medium, and long term. The outcomes of their meetings were reviewed in a two-day consolidation workshop with prioritised challenges and strategies to address them.

This HRH Strategy 2017-2021 provides a framework to guide investments and activities to achieve the vision, goal, and objectives set forth in the recently revised HRH Policy 2017-2021. This strategy relies on a multi-sector and sector-wide approach; the objectives, strategies, and activities contained in the strategy consider a wide range of actors, including the Ministry of Education, Science, and Technology (MEST); Ministry of Finance and Economic Development (MoFED); regulatory and professional bodies; for- and non-profit organisations; and faith-based organisations. It outlines the intervention areas, measurable targets, and a monitoring and evaluation (M&E) framework necessary to train, manage, and regulate an appropriate health workforce with the right skills in the right places to meet the country's health needs. Through this HRH Strategy, GoSL aims to plan, produce, deploy, and maintain a resilient, highly-motivated health workforce that can contribute to national socioeconomic development by ensuring equitable, affordable, and high-quality health care services for the population of Sierra Leone. Throughout the strategy process, the stakeholders prioritised quality improvements across the health workforce. Therefore this strategy differs from similar strategies in that it does not only primarily increase the number of workers, but focuses on improving quality before increasing the number of workers.

The intervention areas and activities that have been outlined to address the highlighted challenges are categorised under the five main strategic objectives defined in the HRH Policy 2016. They seek to:

1. **Enhance evidence-based HRH decision-making for the rational management and financing of health workers**

Under this strategic objective, MoHS aims to improve the collection, quality, use, and availability of health workforce data to ensure that evidence- and needs-based decisions are made by GoSL. Fundamental to this strategic objective are the improvement of existing and the introduction of new MoHS information- and evidence-based systems including the integrated Human Resources Information System (iHRIS) and the District Health Information System (DHIS2). Information from these systems must be accessible to all levels of MoHS and relevant partners. Alongside the Government's commitment to evidence-based decisions is the need to identify and advocate for the fiscal space necessary for financially sustainable health workforce development.

2. **Improve HRH production to address national health needs and meet health personnel requirements**

Under this strategic objective, MoHS aims to improve the quality and quantity of its health workers. Immediate plans include investments in increasing production of professionals in midwifery and higher nursing along with strengthening the capacity of Community Health Workers (CHWs). During 2017,

MoHS will also complement these investments with planning to determine how community-level cadres should evolve to respond to future primary care needs, which will then contribute to a long-term training plan. As the strategy development prioritised quality of training over quantity, strengthening clinical components of training will be a key focus. Further, the government is prioritising establishing systems for improved coordination of in-service training as well as clinical mentoring and supervision.

3. Strengthen governance, leadership, and management for HRH

Under this strategic objective, MoHS aims to strengthen its capacity to effectively plan and manage the national health workforce at the central and, especially, at the district level. Doing so requires investments in the leadership and management capacity at all levels of MoHS and in public health facilities – ensuring staff have the tools and knowledge necessary to make evidence-based decisions about the workforce. Additionally, critical investments should be made in the regulatory bodies and agencies that ensure the quality of health workforce training and service provision. Finally, these investments must be accompanied by communication among stakeholders in the health sector so that all actors have access to relevant, timely information to inform management and leadership decision-making.

4. Establish and promote partnerships among public, private and not-for-profit stakeholders

Under this strategic objective, MoHS aims to establish the cooperation and partnership from all sectors necessary to achieve the goal of this HRH Strategy. Across the government and regulatory agencies, inter-ministerial coordination is necessary to plan for, develop, and finance the national workforce. Within MoHS, effective, community-based participation is necessary to improve health worker accountability and management. Partnerships with private-sector, non-governmental, and faith-based organisations in service delivery, education, and technology is paramount to resourcing and implementing the HRH Strategy successfully. Regional and global technical partnerships are also needed to assist the government to accomplish the strategic objectives laid out in the HRH Strategy.

5. Support resource mobilisation and advocacy efforts to ensure the implementation of the HRH Policy and Strategy

Under this strategic objective, MoHS aims to mobilise the resources necessary to fully implement the HRH Strategy. Sierra Leone requires additional investment to develop, manage, and maintain its health workforce to achieve the objectives in the HRH Strategy. MoHS will work with development partners to integrate improved data collection and analysis with budget development and prioritisation of funding.

For each of these strategic objectives, several operational activities have been identified. They have been broken down into operational activities in the immediate (2017), medium term (2018-2020), or long term (2021 and beyond). Performance indicators have also been established for measuring the performance of the programme and progress against the set objectives and targets as part of ongoing monitoring and evaluation of the overall strategic plan.

The effective and successful implementation of this HRH Strategy will be highly dependent on the sustained focus, dedication, engagement, collaboration, and commitments of all the key stakeholders from government and private sectors, development partners, and staff of relevant ministries to stimulate and manage all the concerted efforts to produce the expected results.

2. Introduction

The health workforce is a crucial pillar in every health sector and Sierra Leone has long suffered from health worker shortages. In the aftermath of the Ebola Virus Disease outbreak, the importance of investing in Sierra Leone's health workforce is more evident than ever. Since then, the Ministry of Health and Sanitation has made significant efforts to rebuild the health sector, with a focus on improving maternal and child health. Strengthening human resources for health (HRH) has been a core component of this work and it is now a central theme in the plan that outlines the President's Recovery Priorities (PRP) for the near future. These priorities include immediate investments to expand and strengthen the nursing and midwifery workforce, as well as the community health workforce, and to improve overall training quality. The PRP also identifies the need to ensure investments are being guided by a long-term vision for HRH in Sierra Leone. Hence, the *Human Resources for Health Policy 2017-2021* and the *Human Resources for Health Strategy 2017-2021* have been developed to provide that guidance and serve as building blocks in the larger effort to strengthen the health sector and improve health outcomes in Sierra Leone.

2.1 Purpose and HRH Policy Directions

This HRH Strategy provides a framework to guide investments and activities to achieve the vision, goal, and objectives set forth in the recently revised *HRH Policy 2017-2021*. The HRH Strategy relies on a multi-sector and sector-wide approach; the objectives, strategies, and activities contained herein consider a wide range of actors including the Ministry of Education, Science, and Technology (MEST), Ministry of Finance and Economic Development (MoFED), regulatory and professional bodies, for- and non-profit organisations, and faith-based organisations. It outlines the intervention areas, measurable targets, and a monitoring and evaluation (M&E) framework necessary to train, manage, and regulate an appropriate health workforce with the right skills in the right places to meet the country's health needs.

The MoHS' **vision** for HRH, defined in the *HRH Policy (*2016), sets the long-term, overall direction of national health workforce development and has served as the starting point for strategic discussions forming the HRH Strategy:

> A resilient health workforce that is delivering cost-effective, evidence-based, and high-quality health care services that are equitable and accessible for the population of Sierra Leone by 2025.

Consequently, the shorter-term **goal** which the Government of Sierra Leone aims to achieve through the *HRH Strategy 2017-2021* is:

> To plan, produce, deploy, and maintain a resilient, highly motivated health workforce that can contribute to national socioeconomic development by ensuring equitable, affordable and high-quality health care services for the population of Sierra Leone.

Further, a set of overarching **strategic objectives** have been defined in the *HRH Policy 2017-2021* and are hence to be achieved through implementing this *HRH Strategy 2017-2021*.

With the aim of improving health outcomes within the context of national and international commitments and policies, the strategic objectives of the HRH Policy are to:

1. Enhance evidence-based HRH decision-making for the rational management, planning, and financing of health workers
2. Improve HRH production to address national health needs and meet health personnel requirements
3. Strengthen governance, leadership, and management for HRH
4. Establish and promote partnerships among public, private, and not-for-profit stakeholders
5. Support resource mobilisation and advocacy efforts to ensure the implementation of the HRH Policy and Strategy

2.2 Key Statistics

Despite significant gains in health outcomes since the end of the civil war in 2002, Sierra Leone has some of the worst health indicators in the world (see Figure 1) and ranks among the lowest, globally, for density of skilled birth attendants relative to the population.

The figure below outlines the health situation in Sierra Leone. It should be noted, however, that the health outcomes data reflects the situation before the recent Ebola epidemic and evidence suggests the outbreak had a negative impact on these figures (Evans, Goldstein, & Popova, 2015).

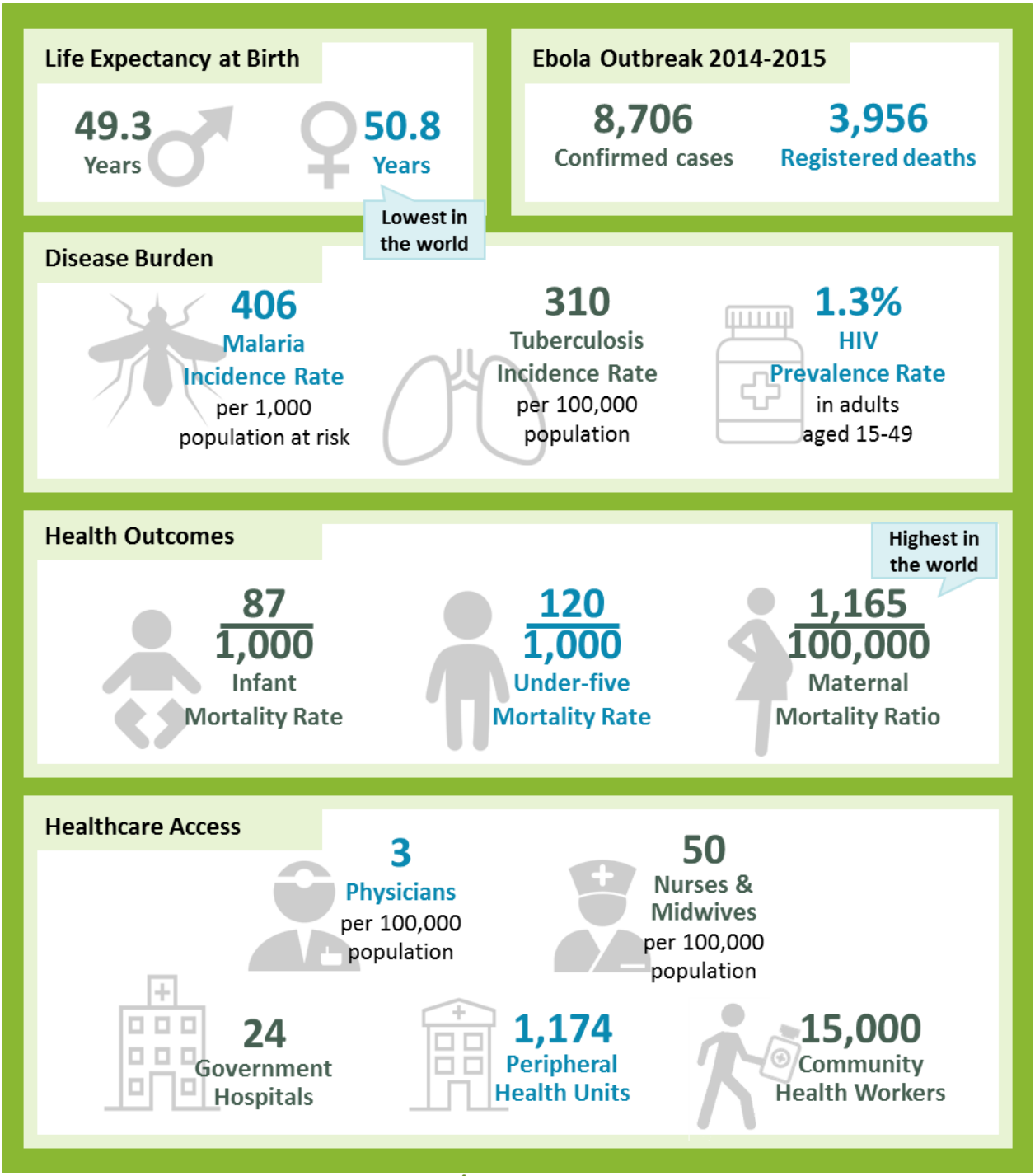

Figure 1. Key health statistics for Sierra Leone[4]

[4] *Data for life expectancy, disease burden and health outcomes from World Health Organization (2016) and UNAIDS (2015) and for Ebola outbreak from Centers for Disease Control and Prevention (2016).*
Health worker to population ratios includes only government employees and is based on data from the 2016 MoHS payroll verification and the 2015 Population and Housing Census (Statistics Sierra Leone)
Total population in Sierra Leone: 7,092,113; Population of under-fives: 938,453 (13.2%)

2.3 Healthcare System and Structures

Public sector health workers, governed by the Ministry of Health and Sanitation (MoHS), provide the majority of health services in Sierra Leone. The Free Health Care Initiative was introduced in 2010 to increase access to health services and reduce user fees. The Free Health Care Initiative provides free maternal and child health services to pregnant women, lactating mothers, and children under five years. The government clinics also provide free malaria testing and treatment services to the entire population.

The 2015 *Basic Package for Essential Health Services* (BPEHS) defines level of care in relation to facility type, which is summarised in the remainder of this section (Ministry of Health and Sanitation, 2015). In Sierra Leone, Peripheral Health Units (PHUs) provide access to primary care and include the following facility types:

- Maternal and Child Health Posts (MCHPs): Situated at the village level, MCHPs serve populations of less than 5,000. These units are intended to be staffed by Maternal and Child Health Aides (MCH Aides) who are trained to provide services including: antenatal care; supervised deliveries; postnatal care; family planning; growth monitoring and promotion for under-five children; immunization; health education; management of minor ailments and referral of cases to the next level.
- Community Health Posts (CHPs): CHPs are situated in small towns serving populations between 5,000 and 10,000 and are staffed by Community Health Assistants (CHAs), State-Enrolled Community Health Nurses (SECHNs) and MCH Aides. They provide the same types of services provided at MCHPs, in addition to prevention and control of communicable diseases and rehabilitation.
- Community Health Centres (CHCs): CHCs are located at chiefdom level and are responsible for supervising all CHPs and MCHPs within a chiefdom. They usually cover a population ranging from 10,000 to 20,000 and include the following staff: Community Health Officers (CHO), SECHNs, MCH Aides, laboratory staff, Epidemiological Disease Control Assistants and Environmental Health Assistants. Patients at CHCs can receive all aforementioned services provided at the CHP level, with the addition of environmental sanitation and basic laboratory services. Additionally, five CHCs per district are designated for basic emergency obstetric and newborn care.

Additionally, Community Health Workers (CHWs) provide primary health care services at the community level, while reporting to and being supervised by PHUs. However, CHWs are not currently part of the civil service. A geo-mapping conducted by MoHS and UNICEF identified 14,632 community-based

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Number of peripheral health units includes only government CHCs, CHPs, and MCHPs, based on data from the MoHS Payroll Audit in February 2016.

individuals working throughout the country (UNICEF & Ministry of Health and Sanitation, 2016). The Directorate of Primary Health Care and its partners launched a national CHW Policy in February 2017 and will launch a national CHW Strategy later in 2017.

For secondary care, 21 government hospitals provide technical support to the PHUs and serve as secondary-level referral facilities for primary health care. Secondary care facilities provide the following health services: outpatient services for referred cases from PHUs; primary care services for the local population within its immediate environs; inpatient (admission) health facilities; diagnostic services; and management of accidents and emergencies.

For tertiary care, three major government hospitals located in Freetown provide specialist health services including general surgery, internal medicine, obstetrics and gynaecology, and paediatrics. These tertiary hospitals are Connaught Hospital, Princess Christian Maternity Hospital, and Ola During Children's Hospital.

The number of government healthcare facilities broken down by level of care is provided in Table 1. Additionally, there are private hospitals and clinics that are at least partially staffed by government health workers, including Sierra Leone-China Friendship Hospital, Emergency Surgical Centre, and Aberdeen Women's Centre; however, these private and public-private-partnership hospitals and PHUs have not been included in the facility count below.

Table 1. Government healthcare facility count by level of care[5]

Level of Care	Facility Type	Number
Tertiary	Referral Hospital	3
Secondary	Hospital (including regional referral hospitals)	21
Primary	Community Health Centre	229
	Community Health Post	386
	Maternal Child Health Post	559
Community	Community Health Worker	~15,000

2.4 Policy Context

This document represents the result of extensive policy development and planning by the Government of Sierra Leone. In 2006, GoSL developed the first *Human Resources for Health Policy* (2006) to guide health workforce development. In 2012, in accordance with the *National Health Sector Strategic Plan 2010-2015* (NHSSP), which provides a common strategic framework to guide interventions by all actors

[5] *Facility information updated as of August 2016, based on facility-level data collection efforts conducted as part of the MoHS payroll audit in early 2016. It does not capture private- or faith-based clinics operating without government staff.*

at all levels of the health system, the HRH Policy was updated and informed the development of the first *Human Resources for Health Strategic Plan 2012-2016*. The HRH Policy and HRH Strategic Plan were complemented by the development of a comprehensive *Scheme of Service* (2010, 2015), which identified pay grades and career ladders for health workers. In this same time period, the *Civil Service Code Regulations and Rules* (2008, 2011) and the *Health Service Commission Act* (2011) were also established to set the regulatory and administrative framework for effectively managing the national health workforce. In 2011, the Government of Sierra Leone also established the National Health Compact to reaffirm the commitment of international partners to the national health priorities identified by MoHS.

In May 2014, in the wake of the devastating Ebola Virus Disease outbreak, MoHS revised the *Basic Package of Essential Health Services* (BPEHS) and developed both the *Health Sector Recovery Plan 2015-2020* (HSRP) as well as the *President's Recovery Priorities (2016)* to guide the reconstruction of the health sector in the near- and long-term. The plans developed and revised in 2014 and 2015 recognise the crucial need for an appropriate health workforce to ensure resilient national health services. Developing a national HRH Policy and Strategy was therefore identified as one of the key activities amongst the President's Recovery Priorities. Consequently, in 2016, as MoHS worked to develop the HRH Strategy and revise the HRH Policy, MoHS also completed a process to review and update the *Community Health Worker Policy* (2012) and initiated the development the first *Nursing and Midwifery Policy* (2016). The costed HRH Strategy spanning 2017-2021 articulated in this document is informed by objectives and priorities stated in these policies and plans.

The current HRH Strategy has also been guided by the regional and global policies and best practices for health sector strengthening and health workforce development, including the *Kampala Declaration and Agenda for Global Action on Health Workforce* (2008), the *Ouagadougou Declaration* (2008), the *World Health Organization Code of Practice on International Recruitment of Health Workers* (2010) and the *Sustainable Development Goals on Health and the Global Strategy on Human Resources for Health: Workforce 2030*.

Table 2. National plans and policies that informed the Sierra Leone HRH Strategic Plan 2017-2021

Overall Health Policies	
• National Health Policy (2002) • National Health Compact (2011) • Agenda for Prosperity 2013-2018	
Overall	**Cadre-Specific**
Policies related to HRH	
• Human Resources for Health Policy (2006, 2012, 2016) • Civil Service Training Policy	• National Community Health Worker Policy (2012) • National Community Health Worker Policy 2016-2020 (2016)
Strategies related to HRH	
• President's Recovery Priorities (2016) • Health Sector Recovery Plan 2015-2020 • National Health Sector Strategic Plan 2010-2015 (2010) • HRH Strategic Plan 2012-2016 (2012) • Basic Package of Essential Health Services (2015)	• Nursing and Midwifery Policy (2016) • Community Health Worker Policy (2017)
Governance/Regulations related to HRH	
• HRH Scheme of Service (2006, 2013, 2015) • Civil Service Code, Regulations and Rules (2009, 2011) • Health Service Commission Act (2011)	• The Medical and Dental Act (2007) • The Pharmacy and Drugs Act (2001) • Nurses and Midwives Act (1960; *new Act not yet implemented developed in 2015*) • Community Health Professionals Act (*New Act not yet implemented, 2016*)

3. Methodology

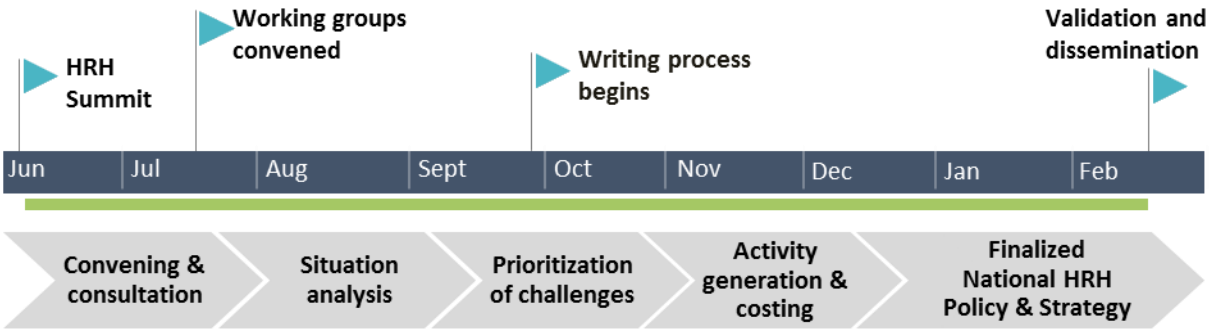
3.1 Process and Partner Coordination

This document represents the culmination of a highly consultative process led by the Government of Sierra Leone that has considered input from more than 260 actors at every level of the health sector. The strategic planning process was formally launched at the June 2016 HRH Summit in Freetown, Sierra Leone. During this summit, national and international participants convened to identify priority challenges to the health sector in Sierra Leone, review best practices for health workforce development and formalise the collaborative and evidence-driven strategy development process to follow.

In July 2016, an inter-ministerial Steering Committee was formed to provide oversight and guidance to the development of the HRH Strategy. The steering committee was co-chaired by the Chief Medical Officer and Permanent Secretary for Health and Sanitation, and included senior MoHS management, as well as senior leaders from the Health Service Commission, the Human Resources Management Office, the College of Medical and Allied Health Sciences, the Ministry of Finance and Economic Development, the Ministry of Education, Science, and Technology, and the Ministry of Local Government and Rural Development. A secretariat led by the Directorate of HRH, with support from the Clinton Health Access Initiative and the World Health Organization, provided process facilitation and continual analyses to support evidence-based decision-making.

From July through November 2016, three technical working groups – each organised around a different thematic area – convened to review evidence on the status of the health workforce and develop activities to address priority challenges in the short-, medium-, and long-term (see *Appendix 3: Composition and focus areas of Technical Committees* for further detail). In September 2016, a two-day consolidation workshop was held for committees to review and agree upon the prioritised challenges and strategies. In November 2016, consultation workshops were held in each region (Makeni, Bo, and Kenema). Attendance included regional administrators, including hospital administrators, and fifteen participants from each district. Findings from technical working groups were then submitted to the inter-ministerial Steering Committee for inclusion in the HRH Strategy.

Starting in November 2016, the prioritised activities were consolidated into a single document and disseminated to key stakeholders for review and validation. The *HRH Strategy 2017-2021* is slated for launch in early 2017.



3.2 Data Generation and Analysis

In early 2016 MoHS completed a situation analysis of the national health workforce, informing the development of the *Sierra Leone HRH Country Profile 2016* and revised HRH Strategy and to guide priority activities under the *National Ebola Recovery Priorities for Sierra Leone 2015-2017*. These analyses are summarised in *HRH Situational Analysis*. Key activities included:

- **Payroll Verification:** The Directorate of HRH and partners worked to improve data quality and availability around the health workforce and complement activities related to the iHRIS exercise. The activity resulted in a cleaned payroll dataset of all MoHS staff, a comprehensive database of the existing health workforce – including the unsalaried workforce – and updated guidelines and standards of practice to streamline and maintain payroll.
- **Human Resource Management Process Mapping**: A comprehensive mapping exercise of HR policies – including hiring, leave, reassignment, and separation – was conducted by MoHS to assess opportunities to streamline HR processes and communicate the current standards of practice for all workers.
- **Health Workforce Pipeline Modeling and Cadre Mapping:** Building on data collected through the payroll verification and from health-workforce training institutions in Sierra Leone, MoHS developed a forecasting model to assess the impact of potential workforce interventions and verify the training capacity of the health workforce sector in Sierra Leone.

3.3 Incorporating best practices and lessons learnt

To further ensure that the activities highlighted in this HRH Strategy are evidence-based, a desk review was conducted to identify and review interventions supporting the development of HRH to improve health outcomes – from within Sierra Leone as well as other countries. These best practices and lessons learned have helped to shape the activities in this strategy to fit the specific context of Sierra Leone. Lessons learned from specific challenges previously encountered when implementing HRH interventions in Sierra Leone are described in the HRH Situational Analysis, whereas relevant international best practices are presented in *Appendix 4: International best practices and evidence*.

4. HRH Situational Analysis

This section provides a brief introduction to core systems, processes, and challenges related to HRH in Sierra Leone and gives an overview of the current health workforce. A more detailed situational analysis with additional challenges and illustrative analyses can be found in the *Sierra Leone HRH Country Profile 2016*.

4.2 Progress since 2011-2016 HRH Strategic Plan and Current HRH Initiatives

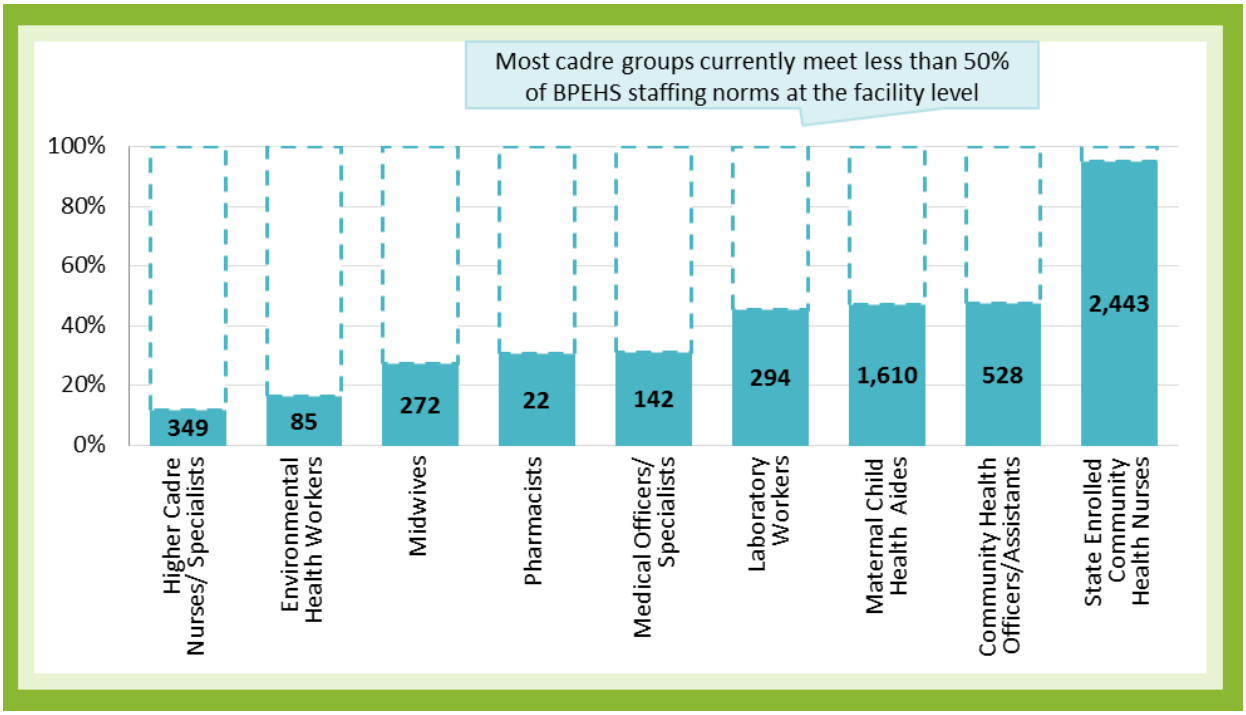
In 2011, the national health workforce numbered just over 8,000.[6] Over the course of the last strategic plan (*HRH Strategic Plan 2012-2016)*, the workforce has grown by roughly 24% to over 9,900 health workers. Further, the MoHS' Directorate of HRH has grown in capacity from five employees in 2011 to 26 in 2016, albeit only five employees have technical and professional backgrounds. This enhanced human resource capacity, combined with a renewed emphasis on HRH as part of the post-Ebola recovery process, has allowed the Directorate of HRH to lead MoHS in several activities aimed at building a more resilient health workforce. Most notably, the Directorate of HRH and its partners recently carried out a series of data collection activities to audit MoHS payroll, populate iHRIS, and model projected health workforce changes over time. This timely improvement in data quality and availability has facilitated development of a new, robust, evidence-based strategy to strengthen the health workforce in Sierra Leone.

4.3 Health Workforce Statistics

Insufficient staffing levels have long been recognised as a key barrier to a resilient and responsive health system in Sierra Leone. To demonstrate these staffing gaps, facility-level staffing norms defined in the BPEHS 2015 can be aggregated to national-level staffing requirements based on the number of government-owned facilities of each type, as counted as part of the 2016 payroll audit, and the average number of wards per hospital (see the HRH Country Profile for a full description of this methodology). As shown in Figure 2 below, the total number of health workers currently employed falls below this aggregated national-level staffing norm for every clinical cadre providing patient services. Staffing gaps are particularly significant for higher-skilled cadres such as doctors, specialist nurses, and midwives.

[6] *Includes health workers on government payroll*

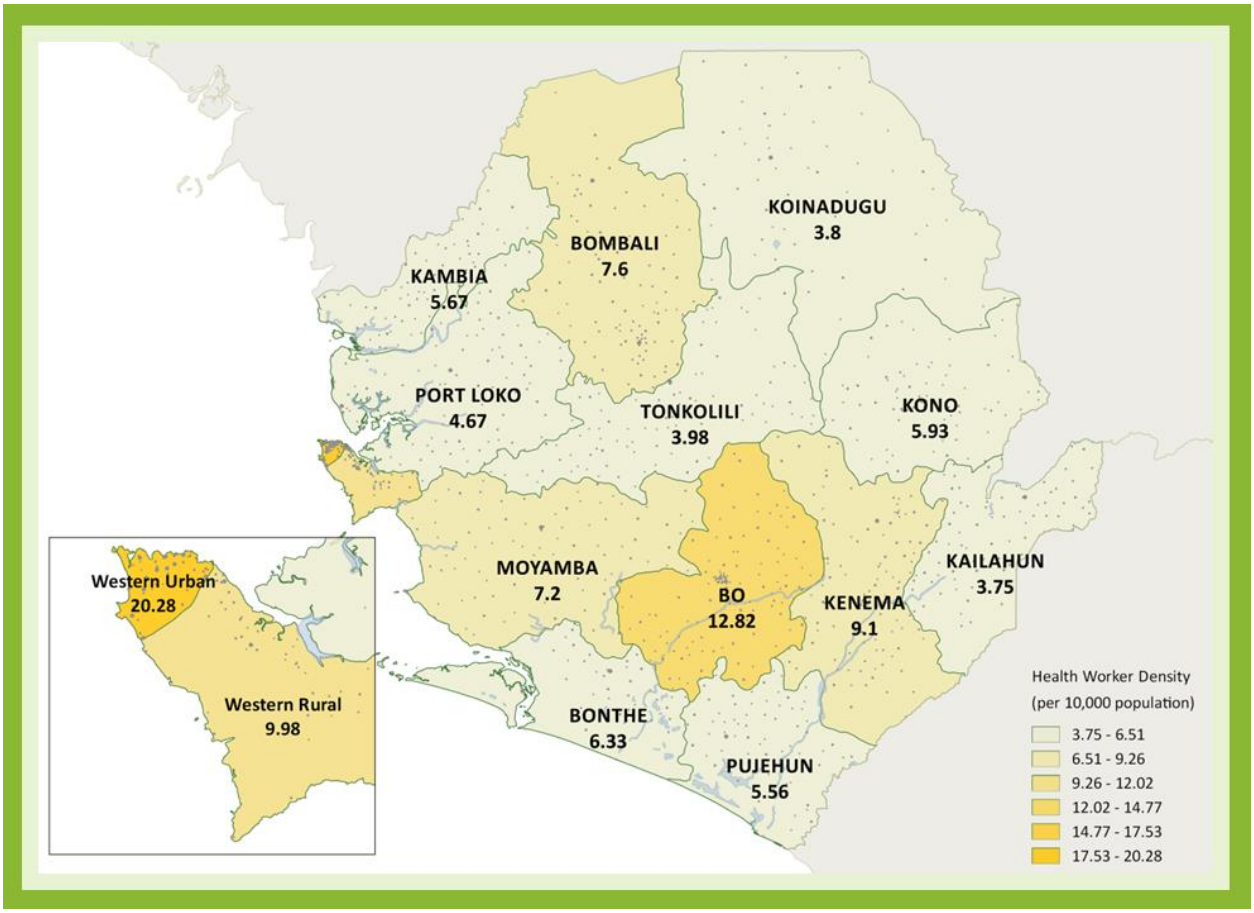
Figure 2. Facility-level staffing gaps for clinical cadres [7][8][9]



Government-employed health workers are highly concentrated in urban areas. Approximately 42% of the workforce currently employed by MoHS is active in Western Area and 10% in Bo district, where the country's second largest city is located, while the remaining 47% of health workers are spread throughout the rest of the country. Even after accounting for relative district populations, the concentration of health workers in Freetown (Western Area Urban) remains noticeable. The density map below (Figure 3) shows the clinical health worker to population ratio by district, with the highest ratio being in Western Area Urban hospitals and PHUs, at 20.8 clinical health workers per 10,000 people (Statistics Sierra Leone, 2016).

[7] *Based on facility-level data collection efforts conducted as part of the MoHS payroll audit in early 2016*
[8] *Includes GoSL-salaried health workers active in facilities only. In addition to these, there are many unsalaried health workers active in facilities but these are not accounted for in the figure (see 4.3 for more detail).*
[9] *BPEHS facility- level staffing norms were aggregated into national norms by multiplying by the number of health workers required at each facility by the number facilities of each type*

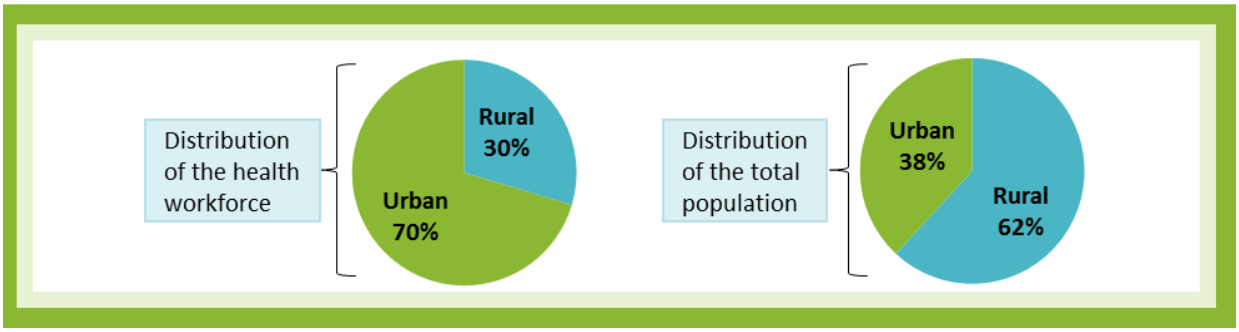
Figure 3. Sierra Leone clinical health workforce density (per 10,000 population)[10]



In aggregate, the concentration of the health workforce in urban areas is significantly more prominent in comparison with the concentration of the total population in urban areas as shown below in Figure 4. The concentration of health workers, particularly highly-skilled clinical staff, in urban areas corresponds with the general availability of advanced care, as all tertiary referral hospitals are located in Freetown and all secondary hospitals are in urban district capitals. Given the limited scope and efficiency of the current referral system, however, this distribution implies a disparity in access to health care between urban and rural settings.

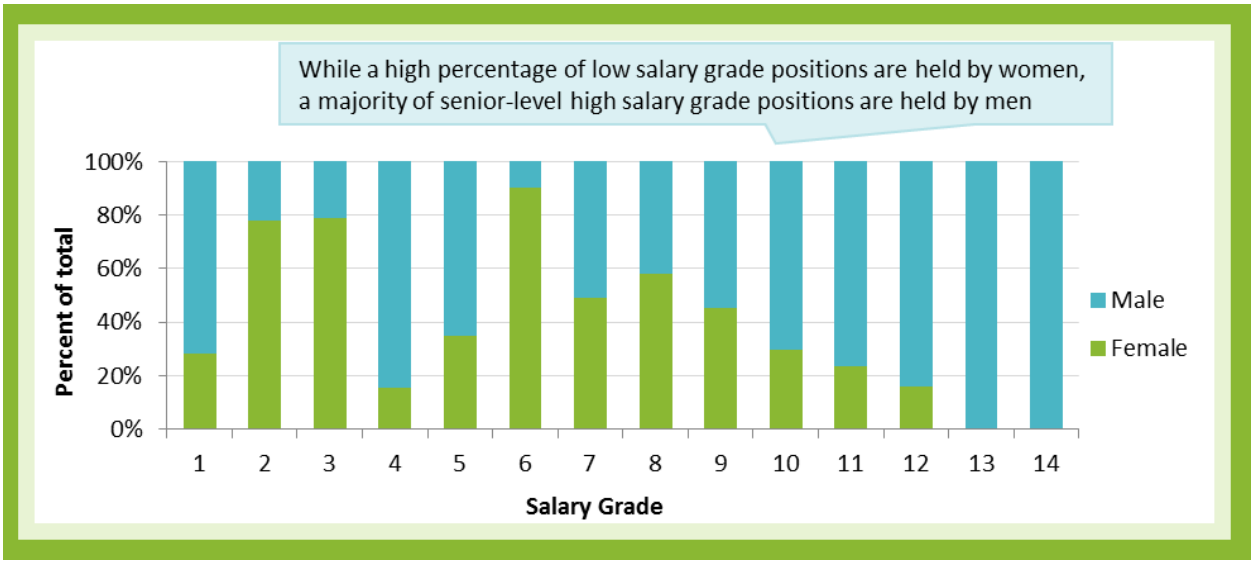
[10] *Includes all salaried health professional cadres and excludes administrative staff, support staff and nursing aides.*

Figure 4. Urban versus rural distribution of the health workforce compared to population[11]



Overall, the MoHS-employed health workforce is 62% female and 37% male. However, there is a clear pattern when looking at the gender distribution across the salary pay scale, which can be used to indicate a combination of skill level and seniority. Lower paid positions tend to be mainly female, while the highest paid positions are filled by males (Figure 5). This can be partially explained by the high percentage of lower-skilled female nurses in the workforce, while the most senior level MoHS positions are often filled by doctors – of which the majority are male.

Figure 5. Gender distribution of the health workforce by salary grade



4.4 Health Worker Production

There are currently 25 national health training institutions offering 56 different health programmes (clinical and non-clinical) from certificate to Master's level. The SECHN certificate course is the largest programme, with 11 schools producing roughly 900 total new graduates per year while, in comparison,

[11] *Health worker distribution is based on the urban/rural classification of the locality where found during the 2016 MoHS Payroll Audit; urban/rural distribution of the total population is from the 2004 Population and Housing Census by Statistics Sierra Leone.*

the single medical officer programme produces approximately 40 new graduates per year. Several new programmes have been introduced since 2011, including a nurse anesthesia programme and CHO specialist training programmes in emergency obstetrics and ophthalmology.

There has been no progress toward establishment of a nationally coordinated pre-service training plan since 2011. As a result, production often exceeds the government's absorption capacity – particularly for lower cadre health workers. This has resulted in over 3,600 unsalaried clinical health workers providing patient services in government facilities despite not being part of the formal MoHS workforce.

4.5 Regulation

There have been few changes in regulation since 2011. Three health professional regulatory bodies – the Nurses and Midwives Board, the Medical and Dental Council, and the Pharmacy Board – are responsible for accrediting health training institutions and licensing health professionals belonging to the represented cadres. Unfortunately, health professional regulatory bodies remain under-resourced, meaning some programmes continue to operate without accreditation, and the licensing process is challenging to enforce and monitor. There are still no regulatory boards for health professionals outside of the nursing, midwifery, pharmacy, medical, and dental cadres.

However, two pieces of legislation with the potential to strengthen regulation of the health workforce are currently awaiting parliamentary approval as of February 2017. Firstly, implementing the *Nurses and Midwives Act* will result in creation of a Nurses and Midwifery Council with greater autonomy and ability to mobilise resources than the current Board. Secondly, the *Community Health Professionals Act* will create a regulatory board for CHOs and CHAs. This will be a significant achievement, as the government is currently unable to regulate the quality of community health professionals even though they provide direct patient care.

4.6 Recruitment, Management and Retention

The overall MoHS-employed health workforce has increased by eight percent since 2012.[12] Responsibility for recruitment and deployment of health workers is currently split across several entities: the civil service's Human Resource Management Office (HRMO), MoHS, and the Health Service Commission (HSC)--which was successfully operationalised in late 2012 and has since taken over health worker recruitment responsibilities from the Public Service Commission (PSC). However, no progress was made toward developing a national deployment policy during the implementation period of the previous *HRH Strategic Plan (2012-2016)*.

[12] *Based on MoHS payroll exports for June 2012 and June 2016*

Management of the health workforce remains highly centralised, with most decision-making power concentrated at the central-level MoHS, HSC, and HRMO. All leave approvals – including study leave, sick leave, annual leave, and maternity leave – must be authorised by the central-level MoHS and HRMO in addition to district and facility leadership. This often leads to significant delays in processing – causing health workers to go on leave without receiving official authorization.

Though national attrition data have historically been poor, one study reported that the Free Healthcare Initiative resulted in improved health worker motivation and retention since 2011 due to larger and more reliable salary payments (Witter, Wurie, & Bertone, The Free Health Care Initiative: how has it affected health workers in Sierra Leone?, 2014). Despite this, rural retention remains a challenge as the government has not been able to sustainably implement an effective remote area allowance scheme. The Global Fund briefly funded a remote area allowance scheme, but the programme was discontinued in mid-2012 due to implementation challenges including insufficient personnel data management processes.

4.7 Performance Management

During the implementation period of the previous *HRH Strategic Plan (2012-2016)*, MoHS worked with HRMO, PSC, and HSC to develop the Individual Performance Appraisal System (IPAS). IPAS provides a framework for employees and supervisors to structure work planning, setting of performance targets, and feedback and reporting twice a year. Three different IPAS forms exist for grades one through six, grades seven through ten, and grades eleven and up. While the Directorate of HRH has conducted preliminary IPAS trainings for health workers grade seven and above, the system has not yet been rolled out to MoHS employees nationwide.

4.8 Health Workforce Financing

At approximately SLL 148 billion (USD 20.5 million) per year as of 2016, the annual MoHS wage bill budget comprises 8.6% of the total Government of Sierra Leone wage bill budget. This is roughly a 60% increase in the total MoHS wage bill since 2012, due to a combination of increased recruitment and annual increases in the salary scales.[13] Donors have supported up to half of MoHS wage bill costs since 2010 – when the workforce doubled with the introduction of the Free Healthcare Initiative. Since 2010, both DFID and the Global Fund have contributed to the health worker wage bill as per the tripartite agreement with GoSL and they issue conditional reimbursements to the government when performance indicators are successfully achieved. GoSL has pre-financed all salary payments with no evidence of significant delays or non-payment. As of February 2017, there were no known workforce funding commitments from donors beyond 2017.

[13] *Based on MoHS payroll exports for June 2012 and June 2016*

4.9 Summary of Key Challenges Identified in the Situational Analysis

The HRH situational analysis identifies many challenges (a comprehensive list is included in the Country Profile) that remain since the previous *HRH Strategic Plan (2012-2016).* These were starting points for strategic planning discussions leading up to this document and are summarised as follows:

Challenges in HRH Production and Regulation

- Supply and demand of health worker production is not sufficiently coordinated to optimise resource allocation within the limited absorption capacity of GoSL.
- Existing health professional regulatory bodies for nursing, midwifery, pharmacy, medical, and dental cadres are under-resourced, while no regulatory bodies currently exist for other health professionals.
- Roughly half of health workers active in government facilities are unsalaried and, hence, not part of the formal health workforce – making it difficult to supervise and regulate these workers.

Challenges in HRH Financing and Planning

- Financial sustainability planning is impeded by a lack of clarity around the future development of GoSL allocation to MoHS wage bill and a lack of funding commitments from external donors beyond 2017.
- Health workforce planning and deployment decisions are not sufficiently evidence based.

Challenges in HRH Management and Governance

- Health workforce management is highly centralised, resulting in long, bureaucratic processes and weak staff monitoring processes.
- There is an overall lack of coordination and communication surrounding HRH matters between MoHS programmes and directorates, between GoSL bodies, and between government, donors, and other stakeholders.
- Rural retention mechanisms are insufficient for motivating and retaining health workers deployed in rural areas.

4.10 Lessons learned from interventions previously attempted to address HRH challenges

Table 3. Lessons learned from previous HRH interventions

Challenge	Lesson learned

Challenge	Lesson learned
Overall strategy implementation: Weak ownership and national engagement in previous HRH strategy Limited implementation from previous HRH Strategy 2012-2016 Inadequate Human and financial resources available	Government ownership and engagement in strategy development is a pre-condition for successful implementation. The HRH Strategy 2017-2021 has gone through a highly consultative process led by the Government of Sierra Leone with input from more than 260 actors, nationally and internationally, at every level of the health sector. The strategy includes some initial costing and highlights a need for thorough financial planning and implementation monitoring with an M and E plan.
Coordinating health worker production: Infeasible training plan in previous HRH Strategy 2012-2016 with limited support across government	Close inter-ministerial collaboration (with MEST and MoFED) is necessary for production planning to be feasible, financially sustainable, and adequately matched to health needs. With the involvement of all mentioned ministries in the HRH Strategy 2017-2021 development process, such collaboration has been initiated and is to be continued through the development of a health worker production plan (see activities under objective 3) and improved financial planning processes (objective 2).
Ensuring holistic health workforce investments that match health needs: Lack of clarity about integration and complementarity between and across cadres – particularly at the community level	A holistic, systemic approach to workforce planning is necessary. Consensus around the future composition of the health workforce at the community level was not achieved through the development of the HRH Strategy 2017-2021. Before long-term production planning can commence, an assessment and recalibration of scopes of practice for all relevant cadres, particularly at the community level, is necessary (objective 3).
Absorbing additional staff onto government payroll: Necessity to address and absorb the high number of so-called volunteers in the health workforce Insufficient funds allocated to health worker salaries by MoFED.	There is continued need for closer continual dialogue between MoHS, HRMO, and MoFED to increase transparency and sustainability of workforce planning. This is the main rationale for instituting the inter-ministerial Steering committee on payroll and financing (objective 2). Moreover, there remains an identified the need for better planning with up-to-date workforce information to ensure effective resource allocation – a lesson that has led the current strategy to focus on workforce data generation, management, and use at the HRH Directorate level (objective 2).
Improving rural retention	The current strategy therefore emphasises the strengthening of

Challenge	Lesson learned
through remote allowances: 2012 remote allowance policy was discontinued following improper attendance monitoring and data management	the attendance monitoring system (objective 1), along with efforts to improve data maintenance and use through iHRIS, before re-considering remote allowances.
Decentralisation efforts: Limited HRH systems and reporting at the district level	There has not been sufficient formal links between central level HRH and the districts. This strategy focuses on establishing such links by introducing district and hospital HR officers and assistants – thereby improving communication streams between the different levels and enabling future de-concentration of HRH management (objective 1).
In-service training effectiveness: Uncoordinated in-service training	MoHS has not had the necessary tools and capacity to coordinate the vast number of training providers. The current strategy acknowledges the need for a policy which defines protocols and guidelines for actors at all levels. Moreover, it identifies a need to develop coordination mechanisms and monitor in-service training participation (objective 3).
Attendance monitoring: Challenges with the implementation of attendance monitoring	Given that attendance monitoring is done at the facility, while subsequent analyses and actions are taken at the central level, the system's effectiveness is contingent on close communication between management levels and prompt responsiveness to challenges. This has proven difficult with the current technical infrastructure and lack of HRH management presence at the district level. Further, discontinuing spot checks due to a lack of financing highlights the importance of financial sustainability planning in core HRH management activities. Drawing from these lessons, the HRH Strategy 2017-2021 aims to leverage the district HR officers and assistants for improved attendance monitoring through i) improving communication at all levels, ii) ensuring any arising challenges can be dealt with in a timely manner and iii) introducing long-term sustainability in spot checking.

5. Strategy

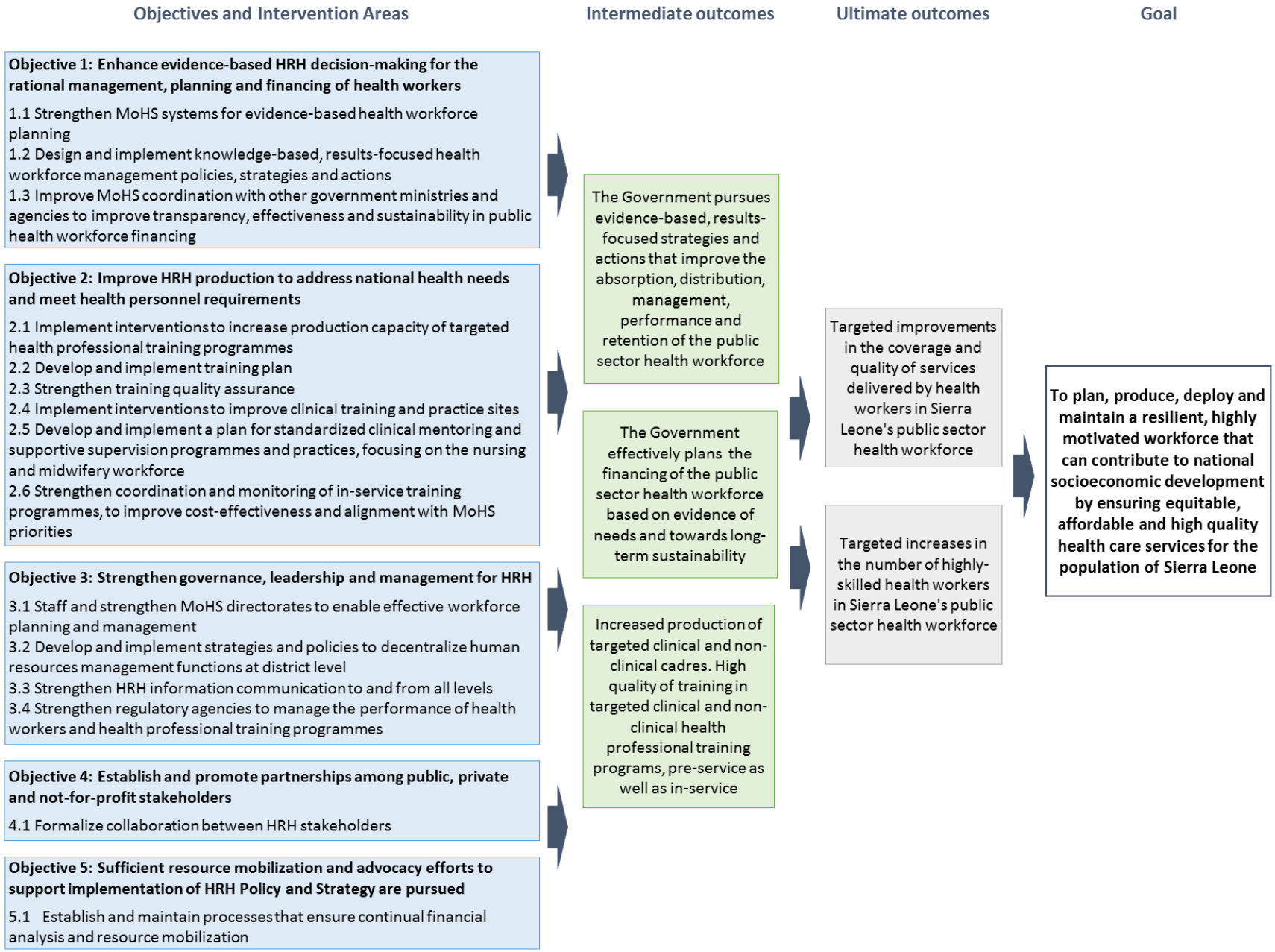
This section outlines intervention areas and activities designed to achieve each of the five strategic objectives defined in the HRH Policy. It also outlines overall implementation strategies, focusing on roles and responsibilities, needs for collaboration, and estimated costs. The timeline for implementation of activities is indicated as immediate term (2017), medium term (2018-2020), or long term (2021 and beyond). The strategy will be reviewed in 2018 to update workforce targets and incorporate further detail on activities currently planned for long term implementation.

Detailed activity planning is found in *Appendix 1: Workplan and Budget for Year 1,* while strategies for monitoring implementation progress and evaluating impact are found in *the Monitoring and Evaluation framework.*

5.1 Theory of Change

The activities included in this strategy are informed by a carefully designed theory of change which identifies the key goal, outcomes, intermediate outcomes, and objectives of implementing the HRH Strategy. The figure below provides an overview of the programme in its entirety.

Figure 6. HRH Strategic Plan 2017-2021 Theory of Change



5.2 Strategies and activities by objective

Objective 1: Enhance evidence-based HRH decision-making for the rational management, planning and financing of health workers

Summary: Under this strategic objective, the MoHS aims to improve the collection, quality, use, and availability of health workforce data to ensure that evidence- and needs-based decisions are made by the Government of Sierra Leone. Fundamental to this strategic objective is the improvement of existing and introduction of new MoHS information- and evidence-based systems including iHRIS and DHIS. Information from these systems must be accessible to all levels of the MoHS and relevant partners. Alongside the Government of Sierra Leone's commitment to evidence-based decisions is the need to identify and advocate for the fiscal space necessary for financially sustainable health workforce development.

1.1 Strengthen MoHS systems for knowledge-based health workforce planning

Strengthening workforce data management and use is instrumental to enhancing needs-based planning and management. This intervention will be implemented in collaboration between the Directorate of HRH and DPPI and will focus on effective HRH information systems and their place in the overall health information systems architecture.

Key activity owners: Directorate of HRH

Key collaborators: DPPI

Activities:

1.1.1 Strengthen national information systems relevant to health workforce planning and management (e.g. iHRIS and DHIS)	*Immediate term:* • Define regular reports from iHRIS and processes for data maintenance *Medium term:* • Formalise plans for integrating payroll, attendance, iHRIS, and DHIS – building on previous work • Roll out iHRIS to districts and other HRH stakeholders such as regulatory boards, health training institutions, other directorates, and HSC
1.1.2 Generate and analyse evidence to inform select health workforce planning and management decisions	*Immediate term:* • Develop evidence base for the annual Manpower Planning Exercise – including use of iHRIS and other HRH data
1.1.3 Conduct HRH research studies to	*Long term:* • Develop a comprehensive labour market study to guide medium and long-

inform HRH policies and strategies	term financing and workforce planning strategies • Develop a private sector, non-governmental, and faith-based organisation workforce study to identify health workforce contribution to private service delivery (this study will also inform labour market study)

Cost estimate: USD 135,000 (SLL 973,000,000)**.** *Major costs include rolling out iHRIS to HRH stakeholders which will require technical support, e.g. to manage infrastructural needs and help define adequate access privileges*.

1.2 Design and implement knowledge-based, results-focused health workforce management policies, strategies, and actions

This intervention aims to create the necessary policy environment for positive and sustainable HRH development. Discussions on key areas were initiated through the strategy development process. The question of potential absorption and future policies on unsalaried workers at government health facilities will be taken forward by the HRH strategy steering committee, while a technical working group has been formed with key stakeholders to develop health worker retention strategies. The Scheme of Service is to be revised under the leadership of HSC after the future composition of the community-level workforce has been reviewed as described under Objective 2.

Key activity owners: Directorate of HRH, HSC

Key collaborators: Professional directorates

Activities:

1.2.1 Design and implement policies related to workforce management at all levels of MoHS; central, district, and health facility	*Immediate term:* • Develop and implement a plan for absorption of critical unsalaried workers, i.e. workers trained as SRNs, midwives, or CHOs, and a policy on remaining unsalaried workers – including relevant management and monitoring procedures for enforcement *Medium term:* • Develop and implement a deployment policy focusing on needs-based planning • Develop and implement a policy on rural retention inclusive of activities such as re-introducing the remote area allowance, establishing housing for health workers in remote areas, and advocating for free health care for health workers in remote areas; taking into account the management infrastructure improvements needed to ensure its effectiveness
1.2.2 Ensure MoHS is operating with adequately up-to-date policies on HRH governance	*Medium term:* • Update the Scheme of Service based on updated scopes of practice (see activity under Objective 2: Improve HRH production to address national health needs and meet health personnel requirements), with particular focus on community-level cadres

	Long term: • Examine the option of health workers becoming public servants and produce recommendations

Cost estimate: (1) USD 6 million (SLL 43 billion) over 5 years on salaries resulting from the absorption of unsalaried health workers in critical cadres[14] (2) USD 24 – 30 million (SLL 173 – 216 billion) on construction of housing for rural health workers (3) USD 4 – 4.5 million (SLL 29 – 32 billion) on remote area allowances (refer to *Appendix 2: Costing methodology and key assumptions* for details) (4) USD 62,000 (SLL 450 million) on estimating and surveying need for rural housing and facilitating updating of Scheme of Service .

1.3 Improve MoHS coordination with other government ministries and agencies to improve transparency, effectiveness and sustainability in public health workforce financing

Under this intervention, a priority for DHRH is to regularly convene the steering committee on planning and resources, which was established during the strategy development process, to pursue opportunities to optimise resource allocation in HRH – mainly by advocating for changes to workforce budgeting processes and working to better coordinate health worker production with absorption capacity.

Key activity owners: Directorate of HRH, Directorate of PHC

Key collaborators: MoFED, MoHS Health Financing Unit, Members of the steering committee on planning and resources, NGO/Donor liaison office, HRH TWG sub-committee on retention

Activities:

1.3.1 Map out and review current financing processes and resource allocation	*Medium term:* • Review MoHS expenditure, specifically the wage bill, and identify potential efficiency gains

[14] *Assumes workers are absorbed in 2017*

1.3.2 Utilise the recently formalised inter-ministerial steering committee on HRH planning and resources to continuously improve workforce planning, inclusive of financing strategies	*Immediate term:* • Advocate for the fiscal space available from gains in payroll efficiency to be allocated to absorbing prioritised qualified health workers currently serving as unsalaried workers *Medium term:* • Develop budget ceiling options or similar into the manpower planning process to increase staff budgeting efficiency in collaboration with the MoFED • Develop strategies to finance the National Community Health Worker Plan 2017-2021 as part of broader health workforce fiscal space planning[15] • Analyse the findings of the forthcoming evaluation of the performance-based financing scheme from an HRH perspective to engage in the planning of its extension or replacement *Long term:* • Improve linkages between the manpower planning process and health worker production (including health professions educators, which are funded by MEST) in collaboration with MEST and regulatory bodies • Investigate means to advocate for increased funds for health worker salaries from MoFED e.g. by matching funding from MoFED by some percentage of internal revenue or ear-marking taxes to health worker salaries while ensuring alignment with broader health financing work within the ministry • Investigate innovative approaches to financing the health workforce, such as establishing a pool for all health funding, while ensuring alignment with broader health financing work within the ministry
1.3.3 Ensure continual availability of up-to-date estimates of long-term fiscal space and costs related to the public health workforce, including commitments made regarding CHWs	*Immediate term:* • Conduct basic fiscal space analysis, with respect to public workforce financing, on a regular basis to inform inter-ministerial steering committee's work *(immediate, medium, long)* • Maintain up-to-date estimates of future salary costs, including any allowances, at any given rate of production and absorption • Use the Health Accounts to track expenditures on HRH or the Service Level Agreements to have an up-to-date overview of HRH interventions

[15] *To be developed within the National CHW Strategy 2017-2021*

1.3.4 Assess appropriate salary levels and retention packages for public health workers	*Medium term:* • Study current level of health workers' remuneration and produce recommendations and follow-up actions – including updated per diem guidelines • Conduct analysis to consider the re-introduction of remote allowances and align them with other allowances and financing schemes while incorporating them into the retention policy (see activity 1.2.1) • Conduct analysis to consider the expansion of housing for health workers in rural areas and incorporating it to the retention policy (see activity 1.2.1) *(medium/long-term)*

Cost estimate: USD 3,000 (SLL 22 million). *Costs mainly associated with conducting meetings.*

Objective 2: Improve HRH production to address national health needs and meet health personnel requirements

Summary: Under this strategic objective, the MoHS aims to improve the quality and quantity of its health workers. Immediate plans include investments in increasing production of professionals in midwifery and higher nursing along with strengthening the capacity of CHWs. During 2017, the MoHS will also complement these investments with planning to determine how community-level cadres should evolve to respond to future primary care needs, which will then contribute to a long-term training plan. As the strategy development prioritized quality of training over quantity, strengthening clinical components of training will be a key focus. Further, the government is prioritizing establishing systems for improved coordination of in-service training as well as clinical mentoring and supervision.

2.1 Implement existing plans for 2017 in pre-service training, to respond to immediate skills gaps

This intervention focuses on expediting implementation of existing pre-service training plans which are in various stages of finalization. *It is important to note that this activity only covers the ministry's immediate plans, while activity 2.2 entails developing a long-term production plan to be implemented starting in 2018, comprehensive of all cadres in the health workforce.* Implementation of intervention 2.1, i.e. 2017 training activities, is managed by each of the cadre leads and training institutions. For CHWs, the implementation of training activities is to be carried out by the Directorate of PHC with partners as detailed in the recently revised CHW policy and strategy.

Key activity owners: COMAHS, Directorate of Nursing Services, Directorate of Hospitals and Labs, Directorate of PHC, Chief Community Health Officer

Key collaborators: Health training institutions, HSC

Activities:

2.1.1 Finalise and implement the already existing plans to strengthen pre-service training across cadres	*Immediate term:*
	The list below outlines these plans by cadre:
	• **Medicine:**
	  ○ Post-graduate medical training: During 2017, this programme will continue to develop and expand. The currently ongoing training of general surgery students will continue and potentially expand, while efforts to accomplish full accreditation for paediatrics training will begin in 2018. Similarly, investments will be made in 2017 to enable accreditation for an OB/GYN programme in subsequent years.
	  ○ Medical training: During 2017, as part of a World Bank-funded programme aimed at strengthening training programs at COMAHS, investments will be made to increase the number and quality of tutors in the MBBS programme.
	• **Pharmacy:** Similar to the medical training, investments will be made to increase the number and quality of tutors in the BPharm programme during 2017. Additionally, the Pharmacy Board is undertaking activities to strengthen the accreditation of training programmes, as described in the regulation section. In the longer-term, stakeholders within the pharmacy area emphasise the need to reassess staffing norms for pharmacists and address needs to increase production numbers.
	• **Midwifery:** The recently initiated Nurse/Midwife Technician programme is scheduled to continue during 2017 to produce its first graduates in 2018, while midwifery programs continue as before. Additionally, efforts will be undertaken in 2017 to prepare for opening an additional training programme that upgrades SECHNs to midwives.
	• **Higher-skilled nurses including specialists:** In this area, the current priority is to upgrade SECHNs to SRNs. 2017 will focus on finalizing the curriculum for this bridging programme and introducing it at targeted training institutions, as well as implementing any necessary associated infrastructural improvements and additional recruitment of tutors. Moreover, preparations will take place to commence specialty training programmes and study abroad programs in priority areas, such as nursing education, critical care, IPC, emergency, and paediatrics.
	• **Lower-skilled nurses:** SECHN training will be scaled down during 2017, by reducing the number of students across programmes, in an effort to better align production with absorption capacity.
	• **Community Health Professionals:** The ongoing BSc programme in

Community Health will produce its first graduates in 2020. Efforts will be undertaken to evaluate the success of their introduction to the health care system and plan curriculum revisions accordingly.

- **Laboratory sciences:** Eastern Polytechnic has recently undertaken significant infrastructural investments constructing a new laboratory. Training is currently being adapted to ensure effective use of the lab and the training institution plans to begin a BSc in Medical Laboratory Sciences programme later in 2017.
- **Public and Environmental Health:** Significant work is currently underway to strengthen this area, in part through strengthened training. This includes the development of a Field Epidemiology Training Programme and a new Masters in Public Health at COMAHS. Moreover, a National Public Health Agency is being established, providing increased emphasis and opportunities for evidence-based interventions in strengthening the public health workforce. The new agency will be evaluating existing training institutions with the target to improve production of public health workers – as well as building the capacity of the existing health workforce (National Public Health Agency, 2017). In addition, the NPHA is developing fellowship programmes for professionals in the following areas: Field Epidemiology, Laboratory, Health Informatics, Health Economics, and Monitoring and Evaluation.
- **Dentistry:** COMAHS, in collaboration with partners, is currently finalizing a Dental Therapist curriculum and will, during 2017, prepare to enrol students in January 2018.
- **Physiotherapy:** Masanga hospital and COMAHS are planning to establish a physiotherapy school with a course of four years. These plans will be advanced during 2017 to potentially allow for the school to open in 2018.
- **Community Health Workers:** Training is a core component of the standardised national Community Health Worker Program, as well as the President's Recovery Priorities. During 2017, activities will be initiated to train all CHWs retained in the revised Programme in a longer, more comprehensive curriculum than previously undertaken – inclusive of new components such as Community-Based Surveillance, household and community mapping enabling targeted interventions to vulnerable populations, and more intensive, timed and targeted maternal, newborn, infant and under-five care. Further, all Peer Supervisors will be trained in supervision skills. Orientation training for all MoHS staff holding key functions in the CHW programme (PHU in-charges, Chiefdom Supervisors, and DHMT CHW Focal Points) will be conducted, to ensure full

understanding of the new components of the CHW programme.

Cost estimate: *These activities are costed and implemented separately from the HRH Strategy.*

2.2 Plan and implement interventions in pre-service training to increase the number of health workers in areas where addressing shortages is critical to meeting the country's health needs

This intervention is focused on developing an evidence-based, long-term production plan for the country that includes new staffing norms for the public health sector. As a first step to revising the norms, stakeholders in nursing and midwifery, CHWs, CHOs, and CHAs will be convened to identify a common view on future roles and responsibilities of community-level health workers such that scopes of practice can be harmonised and made complementary; an activity that will require close engagement from MoHS leadership and is therefore owned by the Chief Medical Officer. As a next step, a national training plan will be developed under the leadership of the DHRH, in close collaboration with professional directorates and training institutions, to identify investments needed to reduce health worker gaps over time. Once final, the training plan will represent a significant portion of strategy implementation costs. Although cost details will not be known until the plan has been fully developed, the strategy includes a preliminary estimate based on current understanding of priority training investments.

Key activity owners: Chief Medical Officer, Directorate of HRH

Key collaborators: Professional directorates, Health training institutions, HSC, MEST

Activities:

2.2.1 Revise the scopes of practice, current as well as future, for community-level cadres (such as Midwives, CHOs, CHAs, SECHNs, MCH Aides, and CHWs)	*Immediate term:* • Identify areas in need of revision, such as overlaps between different cadres' scopes of practice and needs arising from desired workforce developments over time, e.g. introduction of new cadres • Determine how the aforementioned cadres should jointly contribute to a long-term vision for the provision of care at the community level • Convene stakeholders to revise scopes of practice for community-level cadres in accordance with the long-term vision, thereby defining the long-term health workforce composition
2.2.2. Develop and implement a long-term national training plan encompassing the whole health system; curative services, preventive services, and managerial	*Immediate term:* • Revise the staffing norms based on the new scopes of practice, taking into account broader health sector strategies and needs for cadres currently not captured in the norms (e.g. health management professionals and administrative staff) • Conduct assessments and quantify needs of targeted health training institutions inclusive of infrastructure, equipment, education materials, educators, and operations • Develop the training plan using revised staffing norms, outcomes of needs

services	assessment, and absorption capacity estimates *Medium term:* • Implement the training plan, providing financial and technical support to increase production capacity of targeted health professional training programmes

Cost estimate: USD 37– 40 million (SLL 266 – 288 billion)*, of which a) USD 34 - 37 million (*SLL 244 – 266 *billion) is to implement the national training plan and includes costs of infrastructure, equipment, and tutors in health training institutions, b) USD 3.1 million (SLL 22 billion) will be added cumulatively to GoSL wage bill, for the period 2017- 2021, due to the absorption of new graduates, and c) USD 124,000 (SLL 895 million) on needs assessments and facilitation.*

Note: Although the details of the national training plan are yet to be developed, overall priorities have been identified throughout the strategy development process and used to estimate the expected costs of future training investments. Further detail on the assumptions and cost inputs are outlined in Appendix 2.

2.3 Strengthen pre-service training quality assurance

This intervention aims to strengthen quality control enablers governing health worker training. Focus is on standardizing clinical curricula and assessing training quality across health training institutions. Activities will be taken forward through the collaboration between regulatory bodies and TEC that was established through the strategy development process. For nursing programs, efforts will be led by the Directorate of Nursing Services and aligned with the ongoing development of a preceptorship programme.

Key activity owners: Regulatory bodies, Directorate of Nursing Services

Key collaborators: TEC, Health training institutions

Activities:

2.3.1 Develop quality standards for health training institutions to deliver high quality pre-clinical and clinical education	*Medium term:* • Develop standards and assessment tools for quality assurance of academic health education in partnership with the Tertiary Education Commission • Develop and strengthen clinical curricula, ultimately culminating in a policy governing clinical components of training, with a particular focus on SECHN and SRN training programmes
2.3.2 Strengthen accreditation of health training programmes	*Immediate term:* • Implement, evaluate, and review the accreditation tool developed by the Nursing and Midwives Board *Medium term:* • Actively disseminate and make information on accredited institutions and programs publicly available (e.g. by TEC publishing the full list in the national gazette)

Cost estimate: USD 186,000 (SLL 1.3 billion). *Key cost drivers are professional fees for technical consultants.*

2.4 Implement interventions to improve clinical training and practice sites

This intervention aims to improve the quality and safety of clinical practice by providing an enabling environment to health workers, focusing on clinical components of pre-service training.

Key activity owners: Directorate of Nursing Services, COMAHS, IPC focal person

Key collaborators: Training institutions, IPC programme

Activities:

2.4.1 Strengthen health training institution coordination with designated teaching	*Medium term:* • Establish coordination mechanisms and monitoring practices between teaching hospitals and institutions to establish clear clinical rotations • Finalise and implement the preceptorship programme being developed for nurses and midwives

facilities	
2.4.2 Implement national teaching hospital standards and guidelines	*Medium term:* • Develop teaching hospital quality standards and guidelines which outline education staffing, infrastructure, equipment, and policy and management needs
2.4.4 Strengthen systems and training for occupational safety and infection prevention and control (IPC)	*Immediate term:* • Strengthen systems and training for IPC, including improving mentorship and advocating for regular supply of relevant commodities in alignment with the IPC strategy *Medium term:* • Re-introduce routine medical checks for health workers • Ensure access to Post-Exposure Prophylaxis for HIV/AIDS and vaccinations for health workers

Cost estimate: USD 2,920,000 (SLL 21 billion). *This costing assumes estimates from the National IPC Action Plan[16] and includes USD 1.2 million (SLL 8.6 billion) on ensuring access to vaccinations and PEP and USD 1.5 million (SLL 11 billion) on IPC supplies and training.*

2.5 Develop and implement a plan for standardised clinical mentoring and supportive supervision programmes and practices focusing on the nursing and midwifery workforce

This intervention addresses the need for strengthened on-the-job mentoring and supervision which has been expressed throughout the strategy development process. Activities will build on the Directorate of Nursing Services' existing system for clinical mentoring and supportive supervision and recent experiences from Emergency Triage Assessment and Treatment (ETAT) work. This is also a priority intervention in the RMNCAH strategy 2017-2021. During the early stages of developing a revised, standardised programme, the Directorate will identify partner hospital(s) to engage in the process and pilot the programme. Collaboration with relevant partners will also be sought for the development of protocols, guidelines, and standards for foreign health workers with the main objectives to ensure complementary roles and skills transfer between foreign and national staff.

Key activity owners: Directorate of Nursing Services

Key collaborators: Targeted hospitals

Activities:

2.5.1 Develop and implement a plan for standardised clinical	*Medium term:* • Develop a vision and plan for standardised, institutionalised clinical mentoring and supportive supervision – including protocols, guidelines, and

[16] *Currently developed as a 3-yr. plan*

mentoring and supportive supervision programmes and practices, focusing on the nursing and midwifery workforce	standards – within nursing and midwifery in line with the RMNCAH Strategy 2017-2021 • Revise and finalise comprehensive protocols, guidelines, and standards for all health workers and medical teams with qualifications from other countries • Support MoHS central and district levels to pilot and scale clinical mentoring and supportive supervision programmes by initially focusing implementation on a pilot district or pilot hospitals

Cost estimate: *Refer to RMNCAH strategy of MoHS for detailed cost estimate.*

2.6 Strengthen coordination and monitoring of in-service training programmes to improve cost-effectiveness and alignment with MoHS priorities while also enabling future CPD programs

This intervention aims to create the necessary policy and management framework to formalise and coordinate in-service training currently being undertaken by MoHS and its partners with the objective to increase resource-efficiency and ensure alignment with MoHS priorities.

Key activity owners: Directorate of HRH

Key collaborators: Professional directorates, in-service training providers, health training institutions, regulatory bodies

Activities:

2.6.1 Strengthen coordination and monitoring of in-service training programmes, to improve cost-effectiveness and alignment with MoHS priorities while also enabling future CPD programs	*Immediate term:* • Conduct mapping of current in-service training programs, providers, and costs • Develop policy for in-service training programmes, in collaboration with professional and regulatory bodies as well as training providers, including principles on use of health training institutions, coordination mechanisms, eligibility criteria, and min/max hours per year per health worker *Medium term:* • Establish structures and processes, at central and district levels, to monitor and coordinate in-service training programmes such as the introduction of iHRIS TRAIN and a standardised certification system *Long term:* • Formalise CPD by establishing structures and processes at regulatory bodies to monitor in-service training provision and participation, linking it up with licensure

Cost estimate: USD 51,000 (SLL 371 million)*. This includes technical assistance for the policy development and strengthening of data maintenance processes.*

Objective 3: Strengthen governance, leadership and management for HRH

Summary: Under this strategic objective, the MoHS aims to strengthen its capacity to effectively plan and manage the national health workforce at the central and, especially, at the district level. Doing so requires investments in the leadership and management capacity at all levels of the MoHS and in public health facilities to ensure staff have the tools and knowledge necessary to make evidence-based decisions about the workforce. Additionally, critical investments should be made in the regulatory bodies and agencies that ensure the quality of health workforce training and service provision. Finally, these investments must be accompanied by communication among stakeholders in the health sector so that all actors have access to relevant, timely information to inform management and leadership decision-making.

3.1 Staff and strengthen MoHS directorates to enable effective workforce planning and management

Activities listed under this intervention directly address challenges in management practices and systems identified during the strategy development process. These activities are expected to improve effectiveness of the Directorate of HRH by focusing on generating and maintaining the necessary evidence required to carry out its mandate. Implementation will also require leadership from other actors, most notably DHMTs in strengthening performance management, and HRMO in enforcing sanctions based on health worker attendance monitoring.

Key activity owners: Directorate of HRH, MoHS Health Financing Unit

Key collaborators: DHMTs, HRMO, HRH TWG members.

Activities:

3.1.1 Strengthen health worker performance management functions of the Directorate of HRH	*Immediate term:* • Improve records management at the Directorate of HRH, ensuring electronic back-up of all paper files *Medium term:* • Roll out the Integrated Performance Appraisal System (IPAS) to all districts and lower grade health workers *Long term:* • Include productivity measures/indicators in performance appraisals
3.1.2 Strengthen attendance monitoring, sanction framework enforcement, and dual employment monitoring	*Immediate term:* • Roll out updated attendance monitoring tool • Institutionalise regular payroll spot checks to maintain payroll integrity building on the already developed spot check framework • Ensure data gathered from strengthened attendance monitoring and spot checks is utilised to enforce sanction framework which requires close collaboration between the Directorate of HRH and HRMO.

	• Collaborate with partners to develop monitoring mechanisms to prevent dual employment • Pilot biometric attendance monitoring at selected hospitals and evaluate impact
3.1.3 Improve national health workforce retention functions managed by the Directorate of HRH	*Immediate term:* • Establish a rural retention committee to design, supervise, and guide interventions (see activity 1.2.1) • Establish a study abroad and scholarship records management system to track bonding agreements for government scholarships • Enforce bonding agreements with midwives, nurse anaesthetists, and surgical midwives *Medium term:* • Clarify, communicate, and enforce the transfer policy and obligatory rural posting[17] *Long term:* • Prioritise health workers in rural areas when scholarship opportunities arise
3.1.4 Establish updated organisational structure and functions of the Directorate of HRH	*Immediate term:* • Develop revised functions and staffing plan for the Directorate of HRH to implement the HRH Strategy • Implement staffing plan – including additional recruitments or contracting of external technical support as needed *Medium term:* • Establish monitoring unit within the Directorate of HRH with the responsibility to monitor attendance and performance data and coordinate supervisions
3.1.5 Resource MoHS Health Financing Unit to support financial aspects of HRH planning and strategy implementation	*Immediate term:* • Establish staffing and training plan • Identify operations activities and costs to implement functions *Medium term:* • Recruit Senior Health Economist to staff the Health Financing Unit
Cost estimate: USD 868,398 (SLL 6.2 billion), *which includes cost of piloting and full scale roll-out of IPAS and capacity addition to the Directorate of HRH including salary costs over 5 years.*	

[17] *Currently, intra-district transfers require only the approval of the District Medical Officer, while inter-district transfers require approval from the central-level MoHS. Health workers are required to practice in a rural posting for a minimum of two years, but this requirement has previously been loosely enforced.*

3.2 Develop and implement strategies and policies to decentralise human resources management functions at district level

This intervention aims to decentralise operational responsibilities of the Directorate of HRH to the district level to make its functioning more responsive and tailored to local needs, thereby increasing health worker satisfaction, performance, and retention. This intervention is primarily driven through the deployment of district- and hospital-level HR officers.

Key activity owners: Directorate of HRH, DHMTs

Key collaborators: HSC, HRMO, Hospital leadership

Activities:

3.2.1 Deploy district level HR Officers	*Immediate term:* • Appoint, train, and deploy district/hospital HR officers and ensure that Terms of Reference are clearly defined and any overlap with existing management staff is highlighted for revision (building on the already developed Terms of Reference)
3.2.2 Develop and implement a plan for decentralising recruitment to the district level with particular focus on lower grade staff	*Medium term:* • Define process to recruit for and post to specific vacancies at the workstation-level – including roles/responsibilities for workstation in-charges, district HR Officers, DHMT leadership, the Directorate of HRH, HSC, and HR Management Office[18] *Long term:* • Evaluate and determine whether recruitment should be further decentralised by including more cadres or by decentralising responsibilities further to the district/hospital level

Cost estimate: USD 330,000 (SLL 2.4 billion). *This includes costs of recruitment, training, and salaries for district-level HR officers in addition to office equipment and infrastructure.*

3.3 Strengthen HRH information communication to and from all levels

This intervention aims to make information available to HRH stakeholders at all levels, with a particular focus on front-line health workers to ensure their access to entitlements and career progression opportunities.

Key activity owners: Directorate of HRH

Key collaborators: DHMTs, DPPI, HSC, Professional directorates, HRH TWG members

[18] *Decentralizing recruitment will initially be done to the extent that government agency mandates are kept unchanged but candidates are able to apply for specific positions at the facility-level as opposed to central positions where location is not indicated; a change designed to improve retention. This will require new ways of collaboration to be established between the Directorate of HRH, HSC, HRMO and DHMTs. The common desire to define such new processes was identified during the strategy development process and it is assumed that it is taken forward under the leadership of the Directorate of HRH during the early stages of the strategy implementation.*

Activities:

3.3.1 Develop systems to disseminate information relevant to health workers at all levels	*Immediate term:* • Implement mHero[19] to allow for regular communication flow to and from health workers • Establish mechanisms for MoHS to promptly respond to staff needs such as a common phone number through which the Directorate of HRH could be reached *Medium term:* • Make a version of iHRIS (or iHRIS-generated reports) publicly available
3.3.2 Develop and disseminate materials to communicate job functions, policies, routine updates to health workers at all levels	*Immediate term:* • Disseminate overview of civil service code processes *Medium term:* • Produce and disseminate overviews of career paths (based on the *Scheme of Service*) and existing career development opportunities • Produce and disseminate job descriptions to inform health workers of current roles and future career progression opportunities with particular focus on community-level cadres (such as Midwives, CHOs, CHAs, SECHNs and MCH Aides)[20] • Disseminate regular HRH bulletin to health workers and other stakeholders
3.3.3 Utilise the HRH Technical Working Group and its sub-committees to communicate and coordinate activities between HRH stakeholders	*Ongoing* • Convene the Technical Working Group regularly (9-12 times per year) to facilitate continual information sharing between its members

Cost estimate: *USD 387,000 (SLL 2.8 billion) of which USD 162,000 (SLL 1.2 billion) is associated with implementation of mHero for which commitments have already been received and USD 155,000 (SLL 1.1 billion) is associated with regular distribution of HRH bulletin to all facilities.*

[19] *mHERO is a digital platform for health worker communication and coordination. It can be used by the MoHS to convey or collect key information, such as availability of supplies at the facility level, through text messaging.*

[20] *This activity builds on an assumption that the revision of the Scheme of Service and development of job descriptions are successfully implemented in the immediate term, under the leadership of HSC and the various professional directorates.*

3.4 Strengthen regulatory agencies to manage the performance of health workers and health professional training programmes

The need for investments to address challenges in health worker licensure and health training accreditation was emphasised in the strategy development process for cadres with existing regulatory bodies as well as for those which such bodies are yet to be created. This intervention includes strengthening legislation as well as regulatory agency capacity.

Key activity owners: Regulatory bodies, Directorate of Hospitals and Labs, Chief Community Health Officer

Key collaborators: Programme of Laboratory Services, Directorate of Environmental Health

Activities

3.4.1 Resource and staff existing boards and councils to conduct health worker and institutions performance monitoring activities	*Immediate term:* • Conduct capacity and needs assessments of established regulatory bodies *Medium term:* • Develop staffing and operations plan and associated costing for regulatory bodies
3.4.2 Strengthen capacity of boards and councils to issue and renew health worker licenses to monitor health worker qualifications standards	*Medium term:* • Establish and strengthen information systems and databases at Boards and Councils • Establish criteria for demonstrating continuing competency for licensure renewal, including skill acquisition or training requirements (continuing professional development) • Establish criteria for demonstrating incompetency or malpractice to suspend, deny,or revoke licenses • Establish due process with an appeals board for cases in which a license is suspended, denied, or revoked
3.4.3 Facilitate the approval of existing regulatory legislation to enhance regulatory agencies autonomy and function	*Immediate term:* • Ensure the law for the creation of the Nursing & Midwifery Council is passed • Ensure the Community Health Professionals Act for the establishment of a regulatory council for CHOs and CHAs (including surgical CHOs) is passed • Ensure the pending amendment for the Pharmacy Board is passed • Ensure the pending amendment for the Medical and Dental Council is passed
3.4.4 Establish new regulatory agencies for allied health	*Medium term:* • Following the approval of the Community Health Professionals Act, establish the regulatory council for CHOs and CHAs (including surgical CHOs)

professionals to conduct health worker and health training institutions' monitoring activities	*Long term:* • Create a regulatory agency, or agencies, for other allied health professionals[21]

Cost estimate: USD 311,000 (SLL 2.2 billion). *A key cost driver is technical and financial support to the Chief CHO to establish a regulatory council for community health professionals.*

Objective 4: Establish and promote partnerships among public, private and not-for-profit stakeholders

Summary: Under this strategic objective, the MoHS aims to establish the cooperation and partnership from all sectors necessary to achieve the goal of this HRH Strategy. Across the government and regulatory agencies, inter-ministerial coordination is necessary to plan for, develop, and finance the national workforce. Partnerships with non-governmental and faith-based organizations in service delivery, education and technology are paramount to resourcing and implementing the HRH Strategy successfully.

4.1 Formalise collaboration between HRH stakeholders

As a start to building the collaborative structures needed to enable effective continuous strategic HRH decision-making, the Directorate of HRH will continue to convene and facilitate the various committees and working groups formed through the strategy development process.

Key activity owners: Directorate of HRH, Regulatory bodies

Key collaborators: MoFED, MEST, HRMO, TEC, Members of the steering committee on payroll and financing, HRH TWG members

Activities:

[21] *Leadership of other allied health professionals needs to determine whether to join the ongoing process of establishing a regulatory council for Community Health Professionals or establish separate regulatory agencies.*

4.1.1 Formalise collaboration between Ministry of Finance and Economic Development, HR Management Office, MoHS and partners, focusing on health workforce planning and financing, including the annual Manpower Planning exercise	*Immediate term:* • Approve the Terms of Reference for the recently established inter-ministerial workforce resources and planning committee
4.1.2 Formalise inter-sectoral collaboration between MoHS, Ministry of Education, Science, and Technology, Tertiary Education Commission, health training institutions, and regulatory bodies on training quality issues	*Medium term:* • Develop and sign Memorandum of Understanding between the regulatory bodies and Tertiary Education Commission, among other things to issue joint statements on training programme assessments and accreditation decisions
4.1.3 Maintain the currently active HRH Technical Working Group and its sub-committees, thereby regularly convening stakeholders in HRH	*Immediate term:* • Revise the Terms of Reference for the Technical Working Group and institute theme (e.g. rural retention) and/or cadre based sub-committees • Increase collaboration with private partners through the Technical Working Group structure

Cost estimate: USD 700 (SLL 5 million). *This includes meeting costs.*

Objective 5: Support resource mobilisation and advocacy efforts to ensure the implementation of the HRH Policy and Strategy

Summary: Under this strategic objective, the MoHS aims to mobilise the resources necessary to fully implement the HRH Strategy. Sierra Leone requires additional investment to develop, manage, and maintain its health workforce to achieve the objectives in the HRH Strategy. The MoHS will work with development partners to integrate improved data collection and analysis with budget development and prioritization of funding.

5.1 Establish and maintain processes that ensure continual financial analysis and resource mobilisation

This intervention aims to establish mechanisms to enable planning and adequate financing of activities listed under the other strategic objectives of the HRH strategy.

Key activity owners: Directorate of HRH, Health Financing Unit

Key collaborators: TWG members, Development partners

Activities:

5.1.1 Establish and maintain processes that ensure continual financial analysis and resource mobilisation	*Ongoing* • Maintain up-to-date, costed implementation plan for HRH Strategy *Immediate term:* • Enable the recently established inter-ministerial steering committee on HRH planning and resources to align and manage investments against the HRH Strategy • Advocate to global and regional partners to resource HRH Strategy

Cost estimate: *Implementation of this activity is expected to be carried out with the current capacity of the Directorate of HRH.*

5.2 Summary of Costs

The costs associated with the HRH strategy 2017 – 2021 can be categorized into:

a. Implementation costs: These are the costs directly associated with implementing and facilitating the activities listed under each of the strategic objectives of the HRH strategy 2017 – 2021.
b. Costs of outcomes: These are costs on expected outcomes resulting from the implementation of the HRH strategy 2017 – 2021.

Table 4. Cost estimate of HRH Strategy 2017-2021

#	Objective	Implementation costs	Costs of outcomes	
			Expenditure item	Estimate
1	Enhance evidence-based HRH	SLL 1.44 billion /	Remote Allowances	SLL 29 – 32 billion / USD 4 – 4.5 million

	decision-making for the rational management, planning and financing of health workers	USD 200,000	Construction of rural housing	173 – 216 billion / USD 24 -30 million
			Addition to wage bill due to absorption of unsalaried workers	43 billion / USD 6 million
2	Improve HRH production to address national health needs and meet health personnel requirements	SLL 23.6 billion / USD 3.3 million	Implementation of National Training Plan	244 – 266 billion / USD 34 – 37 million
			Addition to wage bill due to absorption of newly produced health workers	22 billion / USD 3 million
3	Strengthen governance, leadership and management for HRH	SLL 13.6 billion / USD 1.9 million	—	—
4	Establish and promote partnerships among public, private and not-for-profit stakeholders	SLL 4.5 million / USD 650	—	—
5	Support resource mobilisation and advocacy efforts to ensure the implementation of the HRH Policy and Strategy	—	—	—
Total (SLL)		**38.7 billion**	**511 – 580 billion**	
Total (USD)		**5.3 million**	**71 million – 80 million**	

5.3 Critical Assumptions and Risks

The strategies and interventions suggested above have been developed to address specific HRH challenges. However, HRH cannot be considered in isolation from the socioeconomic, political, legal, and health context of Sierra Leone. Factors in the external environment may adversely affect the HRH situation and the overall performance of the health sector during the five-year implementation period. Some of these risk factors will be addressed directly within the strategy, while others may need to be addressed with longer-term measures, depending on the degree of severity. The table below summarises some of the potential risks associated with the HRH Strategy 2017-2021:

Table 5. Risks, assumptions and mitigating strategies

Assumption	Risk	Possible consequences	Mitigation strategy

The Government will improve general health financing functions that underpin workforce financing activities.	The strategy does not receive sufficient support from partners. Partners' priorities change during implementation of the strategy because of administrative or political changes.	The strategy is only partly implemented, impeding comprehensive achievement of objectives.	▪ GoSL continues to fund a large part of the strategy (whole wage bill). ▪ Ensure resource mobilisation is ongoing and targeted. Establish workforce planning and resources committee to coordinate activities. ▪ Engage partners during strategy development to allow for maximal alignment with their priorities. ▪ Refine costing during annual review process, including updates to donor priorities.
Partners will use the prioritised activities in the HRH Strategy for their programme planning.	Partners' pre-determined programmatic plans fail to align with the prioritised activities in the strategy. Delays occur in the establishment of coordination mechanisms between MoHS and stakeholders, both at the central and district levels.	The misalignment of partner priorities with HRH Strategy activities leads to differential programming, conflicting priorities, and fragmented systems.	▪ Plan regular review meetings, with M&E plan informing decisions. ▪ Strengthen HR information systems to ensure flow of data between stakeholders. ▪ Engage technical working groups to review and agree on yearly work plans. ▪ Engage partners during strategy development and implementation to align priorities. ▪ Implement SLA to align partner priorities with HRH Strategy activities.
The country will enjoy political stability and progressive economic growth.	Fluctuations in macroeconomic growth result in reduced GoSL funding available for allocation to the health sector.	Increased challenges related to budgeting and management of human and financial resources leads to the need to cut certain activities.	▪ Establish M&E and progress reporting mechanism to assess implementation progress of activities at all levels biannually. ▪ Establish comprehensive revision process to ensure implementation plans are realistically aligned with financial resources.

	Electoral processes result in instability, leading to important changes in timelines.	Changes in priorities to meet political and socio-economic needs result in delays and discontinuity in implementation of the HRH Strategy.	▪ Categorise activities into immediate, medium, and long term to ensure interventions are prioritised.
	Epidemics or other emergencies lead to changes in government funding priorities.		
	HRH Directorate staffing falls short of the required staff capacity to undertake effective implementation and monitoring of the strategy.	Insufficient capacity to meet timelines leads to increased costs and delays in implementation.	▪ Increase recruitment and technical assistance provision where possible to meet staffing requirements.

5.4 Cross-cutting themes

Reducing and managing the unsalaried workforce

As described in *HRH Situational Analysis*, nearly half of the health workers active in government facilities do not receive a formal salary from MoHS, meaning they are not subject to the same degree of management and regulation as the formal health workforce. Addressing the challenges presented by a sizeable unsalaried and unregulated workforce is complex, and will be dependent on the implementation of a number of different strategy activities. In particular, there are two types of questions that will need to be addressed: 1) how to manage, regulate, and selectively absorb the current unsalaried workforce and 2) how to prevent a large unsalaried workforce in the future.

1) How to manage, regulate and selectively absorb the current unsalaried workforce?

The Directorate of HRH, under the guidance of the HRH Strategy Steering Committee, has developed a draft plan for absorbing unsalaried workers on a needs-driven basis. This means that absorption priority will be given to higher skilled workers for which staffing levels fall most significantly below BPEHS staffing norms – such as SRNs, midwives, and CHOs. In addition, DHRH and the Steering Committee will develop a policy on the remaining unsalaried workers to guide monitoring and regulation of these health workers until all are absorbed, retrained, or removed from facilities. This policy will also include a plan for preventing informal recruitment at the facility level. Other activities in the strategy focusing on

strengthening regulation and management will be critical for enforcement of the developed deployment policy. These include strengthening national information systems to improve the ability of MoHS to monitor all health workers and decentralising management functions in order to strengthen district and facility level oversight of health workers.

2) How to prevent a large unsalaried workforce in the future?

Strategy activities focused on aligning production with absorption capacity and workforce needs are necessary in order to prevent the unsalaried workforce from growing. To better align pre-service training with health workforce staffing needs, DHRH will:

- Lead MoHS in developing a comprehensive training plan. Development of this plan will include review of cadre-specific scopes of practice, revision of facility level staffing norms, and an absorption capacity assessment taking into account wage bill growth over time.
- Improve coordination between MoHS, MEST, and MoFED with particular focus on aligning financial projections with production projections through the workforce planning committee.
- Conduct a labour market assessment to understand how excess health worker production can be mitigated by private sector absorption.

Monitoring and reducing health worker absenteeism

Health worker absenteeism was highlighted as a priority challenge throughout development of the HRH Strategy. This cross-cutting issue will be addressed with a combination of activities related to monitoring, management, and communication – with the ultimate aims of improving health worker attendance, keeping personnel records up-to-date, and ensuring that MoHS payroll remains clean on an ongoing basis.

Monitoring

Firstly, the HRH Strategy includes several activities aimed at improving attendance monitoring at the facility level, including:

- Rolling out an updated electronic attendance monitoring tool
- Piloting biometric attendance technology at selected major hospitals
- Conducting unannounced attendance “spot-checks” at the facility level

Additionally, the HRH Strategy includes activities to establish monitoring mechanisms to prevent dual employment of MoHS-employed health workers, which negatively impacts health worker attendance in government facilities. One such activity is to publish a limited version of the iHRIS to allow partners to assess whether prospective employees are already employed by MoHS.

Management

There are also many interventions aimed at improving HR management that will directly impact attendance. For example, one aim in decentralising HR management is to improve attendance monitoring and personnel records management by encouraging direct supervision and accountability

over human resources at the district level. Similarly, rolling out a formalised performance appraisal system will strengthen supervisory relationships between health workers and their in-charges with the ultimate goal of improving engagement and performance at the facility level.

To ensure a robust and holistic approach to attendance monitoring, DHRH will implement health worker monitoring and management activities in combination with enforcement of the sanction framework. Innovative ways of linking regular attendance to incentives, such as PBF or career advancement opportunities, will also be explored through the HRH technical working group during the HRH Strategy implementation period

Communication

Beyond performance management, there are activities in the strategy that aim to strengthen communication to and from health workers in order to improve motivation and attendance – including establishing an HR bulletin and a phone line for direct communication with DHRH. As part of the HRH Strategy implementation, DHRH will also disseminate information directly to health workers on the civil service code and career development opportunities. This dissemination of civil service process information also links back to the interventions targeting monitoring and prevention of dual employment. Health workers should have the agency to pursue career development opportunities in the private or NGO sector, but they must be informed of their options for pursuing these opportunities in a way that is approved and trackable by MoHS.

Improving retention of health workers in rural areas

Rural retention was highlighted as a key challenge during development of the HRH Strategy, based on the significant concentration of health workers in urban areas and the existing body of research on health workforce retention in Sierra Leone (Witter & Wurie, 2014) (Narayan, 2015). As factors contributing to poor rural retention are complex, rural retention is thought to be best addressed through a robust package of interventions that cut across thematic areas of educational opportunity, regulation, financial incentives, personal and professional support, and strong human resource management (Lehmann, Dieleman, & Martineau, 2008) (World Health Organization, 2010) (Araujo & Maeda, 2013).

Thus, to address the challenge of rural retention, the HRH Strategy will take the approach of developing a comprehensive, bundled package of interventions ranging in breadth and cost. This package will include two primary longer term interventions to improve rural retention through incentivization: the reinstatement of a remote area allowance and the provision of health worker accommodation. As a way of further developing and coordinating the various interventions needed as part of the package to improve rural retention, DHRH will lead the formation of a technical working group focusing on health workforce rural retention.

Finally, there are a number of interventions in the HRH Strategy that may impact rural retention when implemented, including:

- *Development of a deployment policy for more rational and evidence-based posting decisions.* Health workers are more likely to stay in rural areas if they have ties to the district to which they are posted.
- *Improved records management and attendance monitoring.* To properly enforce rural bonding agreements, DHRH must be able to track health worker attendance and enact sanctions when rural posts are abandoned.
- *Improved study leave and scholarship tracking mechanisms.* This activity will allow DHRH to give scholarship preference to rural health workers, and to ensure health workers return to their posts upon study leave completion.
- *Decentralisation of HRH functions to the district level.* This activity will reduce the need for health workers to take costly and inefficient trips to and from rural areas in order to settle HR matters. Decentralisation of recruitment will also mean health workers are more likely to be recruited in the district where they want to work, thus increasing the likelihood for retention.
- *Improved clinical mentoring and supportive supervision.* Health workers will be more motivated to perform if they are better mentored and supervised.

The technical working group will both oversee and advise on these activities and take the lead on developing additional interventions throughout the course of the HRH Strategy implementation period.

6. Monitoring and Evaluation Framework

This M&E framework is based on the principles of demonstrating results through an efficient and effective monitoring and reporting system, keeping the system simple using existing data sources wherever possible, supporting the timely identification of challenges and communication of progress. The framework outlines a plan for:

- Continual assessment of the implementation of activities outlined in the HRH Strategy, with the purpose of identifying and mitigating bottlenecks as needed
- Reporting to MoHS technical staff, international partners, donors and other stakeholders on the extent to which implementation of the HRH strategy is achieving its desired objectives
- Evaluation of specific results of the HRH Strategy implementation while contributing to the evidence base for effective of interventions in selected areas
- Support to strengthen national information systems, satisfying short-term decision making needs and providing a sustainable approach to the generation of policy-relevant data

To achieve the above objectives, the framework includes the following:

1. Processes to coordinate and track implementation across government agencies and partner organisations, and to compile and disseminate findings for learning
2. Routine monitoring indicators for the measurement of HRH strategy activities and outputs, with appropriate data sources listed
3. Suggested tools and special studies for evaluating the impact of interventions in selected areas

The complete M&E framework is available as a separate document.

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8. Appendices

Appendix 1: Workplan and Budget for Year 1

Draft Work Plan Year 1 HRH Strategy 2017-2021

The following is a draft work-plan for Year 1 of the HRH Strategy 2017-2021 including the activities, targets and estimated costs for the various activities.

Table 6. Draft workplan for the first year of the HRH Strategy

Activity	Sub-activity	Activity owner	Target/ Output	Estimated cost
1.1.1 Strengthen national information systems relevant to health workforce planning and management (e.g. iHRIS and DHIS)	Define regular reports from iHRIS and processes for data maintenance	Director HRH	iHRIS data is up to date and used to inform HRH management decisions on an ongoing basis, by June end	No Cost
1.1.2 Generate and analyse evidence to inform select health workforce planning and management decisions	Develop evidence base for the annual Planning Exercise, including use of iHRIS and other HRH data	Director HRH	Standard operating procedures for using data in the process are defined by end of April	No Cost

Activity	Sub-activity	Activity owner	Target/ Output	Estimated cost
1.2.1 Design and communicate policies related to workforce management at all levels of MoHS; central, district and health facility	Develop and implement a plan for absorption of critical unsalaried workers, i.e. workers trained as SRNs, midwives or CHOs, and a policy on remaining unsalaried workers, including relevant management and monitoring procedures for enforcement	Director HRH	Absorption plan and policy for trained unsalaried health workers are developed and used for recruitment and management of health workers by end of April	SLL 8.8 million / USD 1,230,000-[22]
1.3.2 Utilise the recently formalised inter-ministerial steering committee on payroll and financing to continuously improve workforce planning, inclusive of financing strategies	Advocate for the fiscal space available from gains in payroll efficiency to be allocated to absorbing prioritised qualified health workers currently serving as unsalaried workers	Director HRH	A clear and costed plan for ring-fencing savings from payroll verification is available by end of March	No Cost
1.3.3 Ensure continual availability of up-to-date estimates of long-term fiscal space and costs related to the public health workforce, including commitments made regarding CHWs	Conduct basic fiscal space analysis, with respect to public workforce financing, on a regular basis to inform inter-ministerial steering committee's work	Health Financing Unit	Fiscal space analysis reports generated and made available every quarter, starting June	No Cost
	Maintain up-to-date estimates of future salary costs, including any allowances, at any given rate of production and absorption	Director HRH	Salary cost estimates available such that can be consulted and at any time by April	No Cost

[22] *Assumes 715 unsalaried health workers are absorbed on pay roll in 2017*

Activity	Sub-activity	Activity owner	Target/ Output	Estimated cost
	Use the Health Accounts to track expenditures on HRH or the Service Level Agreements to have an up-to-date overview of HRH interventions	Health Financing Unit, Donor liaison	HRH expenditures tracked as part of the NHA 2015 exercise	No Cost
2.1.1 Finalise and implement the already existing plans to strengthen pre-service training across cadres.	This includes the following cadres: • Medicine (Post-graduate medical training and Medical training) • Pharmacy • Midwifery • Higher-skilled nurses including specialists • Lower-skilled nurses: • Community Health Professionals • Laboratory sciences: • Public and Environmental Health • Community Health Workers	CNMO, CMO	60 nurses completing 12 out of 18 months of graduate training programme by November.	Costed outside the HRH Strategy
2.2.1 Revise the scopes of practice, current as well as future, for community-level cadres (such as Midwives, CHOs, CHAs, SECHNs, MCH Aides and CHWs)	Identify areas in need of revision, such as overlaps between different cadres' scopes of practice and needs arising from desired workforce developments over time, e.g. introduction of new cadres	CNMO, Director PHC, Chief CHO	Groundwork for cross-cadre discussion on scopes of practices laid by end of April	SLL 252 million / USD 35,000
	Determine how the aforementioned cadres should jointly contribute to a long-term vision for the provision of care at the community-level	CNMO, Director PHC, Chief CHO	Short and long term community intervention plans developed by end of September	

Activity	Sub-activity	Activity owner	Target/ Output	Estimated cost
	Convene stakeholders to revise scopes of practice for community-level cadres in accordance with the long-term vision, thereby defining the long-term health workforce composition	Director HRH, HSC	Scopes of practices for community level cadres reviewed and clear recommendations made for areas to be revised by end of December.	SLL 129 million / USD 18,000
2.2.2 Develop and implement a long-term national training plan encompassing the whole health system; curative services, preventive services as well as managerial services	Revise the staffing norms based on the new scopes of practice, taking into account broader health sector strategies and needs for cadres currently not captured in the norms, e.g. health management professionals and administrative staff	Director HRH	Revision of staffing norms started by end of September	SLL 93 million / USD 13,000
	Conduct assessments and quantify needs of targeted health training institutions inclusive of infrastructure, equipment, education materials, educators and operations	Director HRH	Needs assessment reports available, with recommendations on how to close existing gaps, by December	SLL 259 million / USD 36,000
	Develop the training plan using revised staffing norms, outcomes of needs assessment and absorption capacity estimates	Director HRH	National training plan in line with National Health Sector Strategic Plan end of 2017	SLL 165 million / USD 23,000[23]

[23] *It should be noted that the implementation of this training plan is not captured in this workplan as it is scheduled for medium term. It will however constitute a significant share of total HRH Strategy implementation costs.*

Activity	Sub-activity	Activity owner	Target/ Output	Estimated cost
2.3.2 Strengthen accreditation of health training programmes	Implement, evaluate and review the accreditation tool developed by the Nursing and Midwives Board	CNMO	Full review report with recommendations available by end of August	SLL 424 million / USD 59,000
2.4.4 Strengthen systems and training for occupational safety and infection prevention and control (IPC)	Strengthen systems and training for IPC, including improving mentorship and advocating for regular supply of relevant commodities in alignment with the IPC strategy,	DPHC	IPC training, M&E and commodity supply plans available and disseminated by end of 2017	Refer National IPC Action Plan
2.6.1 Strengthen coordination and monitoring of in-service training programmes, to improve cost-effectiveness and alignment with MoHS priorities while also enabling future CPD programs	Conduct mapping of current in-service training programs, providers and costs	Director HRH	Mapping available for use by MoHS and regulatory bodies.	SLL 165 million / USD 23,000
	Develop policy for in-service training programmes, in collaboration with professional bodies and providers; including principles on use of health training institutions, coordination mechanisms, eligibility criteria, min/max hours per year per health worker	Director HRH	In-service training policy available with implementation plans by end of December	SLL 18 million / USD 12,000
	Establish structures and processes, at central and district levels, to monitor and coordinate in-service training programmes, such as the introduction of iHRIS TRAIN and a standardised certification system	Director HRH	In-service structures established at the central level and in all districts by end of 2017	SLL 345 million / USD 48,000

Activity	Sub-activity	Activity owner	Target/ Output	Estimated cost
3.1.1 Strengthen health worker performance management functions of the Directorate of HRH	Improve records management at the Directorate of HRH, ensuring electronic back-up of all paper files	Director HRH	All paper files scanned and backed up in a server by end of 2017	SLL 43 million USD 6,000
3.1.2 Strengthen attendance monitoring, sanction framework enforcement and dual employment monitoring	Roll out updated attendance monitoring tool	Director HRH	Tool in use at all levels, in all districts, by June 2017	SLL 129 million / USD 18,000
	Institutionalise regular payroll spot checks to maintain payroll integrity, building on the already developed spot check framework	Director HRH	Payroll spot checks take place in targeted districts and health facilities once every quarter	SLL 316 million / USD 44,000
	Ensure data gathered from strengthened attendance monitoring and spot checks is utilised to enforce sanction framework	Director HRH	Recommendations from spot checks and attendance monitoring are fully implemented on an ongoing basis by end of 2017.	No cost
	Collaborate with partners to develop monitoring mechanisms to prevent dual employment	Director HRH	Tools for tracking dual employment are developed and effectively used by all partners by end of 2017.	No Cost
	Pilot biometric attendance monitoring at selected hospitals; evaluate impact	Director HRH	Concise results assessment report developed with clear recommendations by end of 2017.	SLL 295 million / USD 41,000

Activity	Sub-activity	Activity owner	Target/ Output	Estimated cost
3.1.3 Improve national health workforce retention functions managed by the Directorate of HRH	Establish a study abroad and scholarship records management system to track bonding agreements for government scholarships	Director HRH	System, including roles and responsibilities, established by end of 2017	SLL 21 million / USD 3,000
	Establish a special rural retention committee to design, supervise and guide interventions (see activity 1.2.1)	Director HRH	Committee established through the HRH TWG by March 2017	No Cost
3.1.4 Establish updated organisational structure and functions of the Directorate of HRH	Develop revised functions and staffing plan for the Directorate of HRH to implement the HRH Strategy	Director HRH	HRH staffing re-organised with clearly distinct roles and responsibilities by June	SLL 52 million / USD 7,200
	Implement staffing plan, including additional recruitments or contracting of external technical support as needed	Director HRH	DHRH staffing re-organised with clearly distinct roles and responsibilities by June	SLL 813 million / USD 113,000[24]
3.1.5 Resource MoHS Health Financing Unit to support financial aspects of HRH planning and strategy implementation	Establish staffing and training plan	Director DPPI	Training and staffing plan developed before June ending	No Cost
	Identify operations activities and costs to implement functions	Director DPPI	Costed activity plan developed by end of August	No Cost

[24] *Provision for costs for 5-year period*

Activity	Sub-activity	Activity owner	Target/ Output	Estimated cost
	Strengthen Human Resources capacity of Health Financing unit	Director DPPI	Recruit health economist by the end of 2017	SLL 1 billion / USD 144,000
3.2.1 Deploy district level HR Officers	Appoint, train, and deploy district/hospital HR officers, ensuring that Terms of Reference are clearly defined and any overlap with existing management staff is highlighted for revision, building on the already developed Terms of Reference.	Director HRH	District HR Officers and HR Assistants deployed to all districts by end of September	SLL 881 million / USD 122,400
3.3.1 Develop systems to disseminate information relevant to	Implement mHero to allow for regular communication flow to and from health workers	Director HRH	mHero rolled out by July	SLL 1.1 billion / USD 162,000
	Establish mechanisms for MoHS to promptly respond to staff needs such as a common phone number through which DHRH could be reached	Director HRH	Phone number acquired and number shared with all districts by end of December	SLL 15 million / USD 2,200
3.3.2 Develop and disseminate materials to communicate job functions, policies, routine updates to health workers at all levels	Disseminate overview of civil service code processes	Director HRH	Civil service code overview drafted and disseminated by end of December	SLL 187 million / USD 26,000

Activity	Sub-activity	Activity owner	Target/ Output	Estimated cost
3.3.3 Utilise the HRH Technical Working Group and its sub-committees to communicate and coordinate activities between HRH stakeholders	Convene the Technical Working Group regularly to facilitate continual information sharing between its members	Director HRH	TWG meetings hold every month and minutes disseminated	SLL 15 million / USD 2,200[25]
3.4.1 Resource and staff existing boards and councils to conduct health worker and institutions performance monitoring activities	Conduct capacity and needs assessments of established regulatory bodies	Regulatory bodies	Needs assessment report available with recommendations by end of November	SLL 316 million / USD 44,000
3.4.2 Strengthen capacity of boards and councils to issue and renew health worker licenses to monitor health worker qualifications standards	Facilitate the review of the due process with an appeals board for cases in which a license is suspended, denied or revoked	Regulatory bodies	Appeals boards is set up with clear ToRs by end of 2017	SLL 122 million / USD 17,000
3.4.3 Facilitate the approval of existing regulatory legislation to enhance	Support the process of ensuring that the law for the creation of the Nursing & Midwifery Council is passed	CNMO	The aforementioned law is passed by end of 2017	SLL 172 million / USD 24,000

[25] *Recurring annual cost*

Activity	Sub-activity	Activity owner	Target/ Output	Estimated cost
regulatory agencies autonomy and function	Support the process of ensuring that the law for the Community Health Professionals Act for the establishment of a regulatory council for CHOs and CHAs is passed	Chief CHO	The aforementioned law is passed by end of 2017	SLL 172 million / USD 24,000
	Support the process of ensuring that the pending amendment for the Pharmacy Board is passed	Registrar Pharmacy Board	The aforementioned law is passed by end of 2017	SLL 172 million / USD 24,000
	Support the process of ensuring that the pending amendment for the Medical and Dental Council is passed	President SLMDC	The aforementioned law is passed by end of 2017	SLL 172 million / USD 24,000
4.1.1 Formalise collaboration between Ministry of Finance and Economic Development, HR Management Office, MoHS and partners, focusing on health workforce planning and financing, including the annual Manpower Planning exercise	Approve the Terms of Reference for the recently established inter-ministerial payroll and workforce resources and planning committee	Director HRH	Aforementioned ToR approved by end of April	No Cost
4.1.3 Maintain the currently active HRH Technical Working Group and its sub-committees, thereby regularly convening stakeholders in HRH	Revise the Terms of Reference for the HRH Technical Working Group and institute theme (e.g. rural retention) and/or cadre based sub-committees	Director HRH	TWG ToRs revised and presented in TWG meeting for review and validation by end of April	No Cost

Activity	Sub-activity	Activity owner	Target/ Output	Estimated cost
4.2.1 Strengthen coordination, collaboration and effective communication between local councils, chiefdom administrations, DHMTs and implementing partners	Continuously review the Service Level Agreements to ensure continued coordination of implementing partners with MoHS at the central and district level, with a special focus on HRH	Donor Liaison	Quarterly meetings held between Director HRH and Donor Liaison Officer to discuss strategies, starting June	No Cost
	Maintain costed implementation plan for HRH Strategy up-to-date	Director HRH	Costed implementation plan available at all times, starting March	No Cost
	Enable the recently established inter-ministerial steering committee on HRH planning and resources to align and manage investments against the HRH Strategy	Health Financing Unit	Quarterly meetings between DHRH and the health financing units	No Cost
	Advocate to global and regional partners to resource HRH Strategy	Director HRH	Funding plan for the HRH Strategy developed and shared with HDPs	No Cost

Appendix 2: Costing methodology and key assumptions

This appendix details the how cost estimates presented in the strategy were developed, with a focus on key underlying assumptions and main inputs.

Objective 1

The costs and associated assumptions for interventions under Objective 1 are presented as:

1. Main cost drivers
2. Other costed interventions

1. Main cost drivers for Objective 1

The main costs associated with the implementation of activities identified under Objective 1, are driven by three activities, a) re-introduction of remote allowances, b) expansion of housing for health workers in rural areas and c) absorption of critical unsalaried workers. a) and b) will be included in a broader rural retention strategy to be developed during 2017 and costs are therefore preliminary estimates at this time. For c), discussions are still ongoing at the ministry leadership level and thus, this cost estimate is also preliminary.

a. Costs of re-introduction of remote allowances

Assumptions

It is assumed that the costs of providing remote area allowances would amount approximately to 5 % of total wage bill of clinical workers. This is in line with the "Remote Area Allowance" scheme that was previously introduced in 2011[26].

Cost estimate

Based on the above assumption, the total spending on rural retention allowances for a five-year period would amount to USD 4 – 4.5 million (SLL 29 – 32 billion), i.e. 5 % of the annual wage bill (for clinical cadres) which is currently at USD 15.5 million (SLL 111 million)[27] and is projected to increase to USD 19.1 million (SLL 137 million) at the current rate of production, absorption and attrition

b. Cost of expansion of housing for health workers in rural areas

Assumptions

- Unit Costs: It is assumed that the construction of housing infrastructure would amount to USD 10,500 – USD 11,000 (SLL 75 – 79 million) per health worker (assumes shared housing). This

[26] *Evaluation of DFID Support to Health Workers Salaries in Sierra Leone - 2012*

[27] *Based on Payroll audit exercise conducted in 2016. Clinical workforce includes all nurses, midwives, physicians, CHA/CHOs, MCH aides, pharmacy, laboratory and environmental health workers on MoHS Payroll (including those performing administrative functions)*

estimate has been based on preliminary estimates for ongoing projects[28] and excludes land acquisition costs.

- Eligibility for housing: Which locations and health workers that are eligible for housing will be determined through the rural retention strategy development. The HRH strategy's preliminary estimate is therefore calculated as a range, where a) the lower amount assumes only selected cadres above grade 4, posted in rural[29] CHCs and CHPs, will be eligible for housing and b) the higher amount assumes all cadres above grade 4, posted in rural CHCs and CHPs, and one health worker per rural MCHP, will be eligible for housing. *These assumptions will be revised as rural retention strategies are finalised.* Other assumptions: It is assumed that land for construction is available within the proximity of the health facility

Cost estimate

Based on these assumptions, the construction of housing facilities for 2,200 - 2,800 health workers in rural areas (based on option chosen for eligibility) is estimated to cost between USD 24 -30 million (SLL 173 – 216 billion) in investments over 5 years.

c. Absorption of critical unsalaried workers

Assumptions

- "Critical unsalaried workers" are defined as health cadres which meet at least two of the following criteria:
  - the current number of salaried health workers is below the staffing targets outlined for that cadre in the BPEHS
  - current levels of health worker production are not estimated to be sufficient to alleviate health worker shortages within the next five years
  - there is evidence that unsalaried health workers areare a challenge for the cadre (i.e. greater than 20 unsalaried health workers)
- Health worker salaries were computed using the weighted average salaries reported in MoHS payroll documents

Cost estimate

Based on the assumptions outlined in this section, the cost of absorbing 715 critical unsalaried workers is SLL 8.9 billion, or USD 1.2 million in 2017 (see table below for breakdown of absorption costs by cadre).

Table 7: Cost estimates for absorption of critical unsalaried workers

[28] *Estimates provided by the MoHS Department of Architectural Services*

[29] *Refers to a facility located in a locality classified as rural; based on facility data collected at the MoHS payroll audit 2016 and Statistics Sierra Leone urban/rural locality classifications.*

Cadre name	Assumed number of unsalaried workers to be absorbed	Preliminary estimate of 2017 cost impact (SLL)
Community Health Assistant	74	820,747,262
Community Health Officer	36	576,895,599
Medical Laboratory Technician	147	2,294,689,208
MCH Aide	387	3,707,031,438
Medical Officer	1	77,001,253
Nursing Officer	26	685,881,192
State Registered Nurse (SRN)	44	694,504,897
Total	**715**	**8,856,750,849**

2. Other costed interventions under Objective 1

In addition to the main cost drivers, the assumptions used for costing other interventions under Objective 1 are summarised in the table below.

Table 8: Assumptions for costing of interventions under Objective 1

#	Activity	Assumptions	Costs
1.1	Strengthen MoHS systems for knowledge-based health workforce planning	The cost drivers assumed for the roll out iHRIS to districts and other HRH stakeholders are primarily on external technical assistance and training costs for MoHS stakeholders.	SLL 288 million / USD 40,000
		It assumed that an external consultant will be engaged to conduct a comprehensive labour market study on financing and manpower planning strategies.	SLL 295 million / USD 41,000
1.2.	Design and implement knowledge-based, results-focused health workforce management policies, strategies and actions	It is estimated that updating the Scheme of Service would entail costs on workshops, meetings and consultations.	SLL 86 million / USD 12,000
		Apart from construction costs that have been discussed in the section on main cost drivers in Objective 1, it is assumed that planning the expansion of housing for health workers in rural areas would entail costs on surveying and estimation of the need.	SLL 324 million / USD 45,000
1.3	Improve MoHS coordination with other government ministries and agencies to improve transparency, effectiveness and sustainability in public health workforce financing	Developing budget ceiling options or similar processes to increase budgeting efficiency require costs for meetings.	SLL 21 million / USD 3,000

Objective 2

The costs and associated assumptions for interventions under Objective 2 are presented as:

1. Main cost drivers
2. Other costed interventions

1. Main cost drivers for Objective 2

Investment in increasing production capacity of health training institutions and the consequent addition to MoHS wage bill are the main cost drivers under Objective 2.

It should be noted that all costs presented in this section are estimates relying on a number of basic assumptions and will be subject to revision during 2017, as staffing norms are revised and a national training plan is developed (see activity number 2.2). They represent projected investments required after 2017.

Assumptions – Production increases by cadre

The following cadres have been prioritised based on discussions held during the strategy development process and analysis of critical workforce gaps (see HRH Country Profile for further detail). This list is however not exhaustive and will be revised in the national training plan to be developed during 2017.

Table 9. Assumptions for increased production by cadre

Cadre	Rationale for prioritising	Assumed intervention
Medical Officers & Medical Specialists	Although projections indicate growing numbers of medical officers and specialists, investments in these cadres are being prioritised due to the need to develop in-country expertise to mentor and train other clinical cadres, to support research and development of Sierra Leone's health system and to support growing tertiary care services in the long term.	Training programme enrolment to be moderately increased.
Midwifery Professionals*	Increasing production of midwifery professionals is critical to improving the poor under-five mortality and maternal mortality indicators in the country, which are national priorities. This need is reflected in the nation's commitment to increasing the number of midwives in the country to 1,145 by 2020.	Expansion of upgrade programs focused on reskilling lower skilled nurses into midwifery professionals.
SRNs*	There is an acute shortage of these nurse cadres which is projected to exist well beyond 2025 without significant intervention.	Training intake increased by 70% by redirecting capacity from current SECHN programs.
Nurse specialists		Moderate scale up of enrolment in Bachelor's level program; Gaps in critical specialties addressed through study-abroad programs
Pharmacists	There is a need to re-evaluate current norms and appropriately scale-up production of this cadre.	Training intake increased by 85 – 95 % of current intake.
Lab technicians	There are challenges in both quality and production capacity of these cadres.	Focus on quality improvements and scale-up of existing programs
Imaging technicians, biomedical engineers		Critical gaps bridged through study abroad programs

Physiotherapists and Dental Therapists	There is a critical gap in production capacity of these cadres	New training programme to be started in existing health training institutions

** It is assumed that these programs draw from the current pool of SECHNs in the next five years and that any salaried SECHN which enters an upgrading programme is replaced on the payroll by an unsalaried SECHN being absorbed. Additionally, schools are assumed to cease production of SECHNs in the first two years such that workforce numbers are maintained at the BPEHS norm level.*

Community-based cadres including CHWs, CHOs, CHAs and MCH Aides are not included in these projections of production increase in view of the need to review scopes to determine the future architecture of this segment of the workforce. While these cadres will be included in the national training plan that is to be developed in 2017, MoHS priorities for up scaling lie within higher-skilled cadres and hence, it is not expected that interventions in the community-level workforce will imply any significant costs.

Assumptions - Production cost inputs

As part of the development of a production plan during 2017, investment needs at individual training institutions will be assessed, and estimates provided in this costing will be refined. Inputs received from key stakeholders as well as data collected on production capacity during the health worker pipeline modeling exercise were used to develop the current cost estimates. The key cost components are:

- Tutors, domestic as well as foreign
- Student assistance and scholarships
- Infrastructure and equipment upgrades
- Curriculum and certification standards upgrade

Total cost estimates

Based on the above, increased production of the identified priority cadres is estimated to cost between USD 34 – USD 37 million (SLL 244 – 266 billion*)* **in investments on training capacity over 5 years.**

Table 10. Total cost estimates per cadre for increased production

#	Cadre	Projected investment on increasing production capacity
1	Medical Officers & Specialists	USD 3 – 4 million / SLL 21 – 29 billion
2	Midwifery	USD 14.5 – 16 million / SLL 104 – 115 billion
3	SRNs	USD 5 million / SLL 36 billion
4	Nurse Specialists	USD 3.9 million / SLL 28 billion
5	Imaging & Biomedical	USD 3,200,000 / SLL 23 billion
6	Laboratory Technicians	USD 1,900,000 / SLL 13 billion
7	Pharmacists	USD 2,000,000 / SLL 14 billion
8	Dental Therapists	USD 470,000 / SLL 3.3 billion
9	Physiotherapists	USD 470,000 / SLL 3.3 billion

Total	**USD 34 - USD 37 million / SLL 244 – 266 billion**

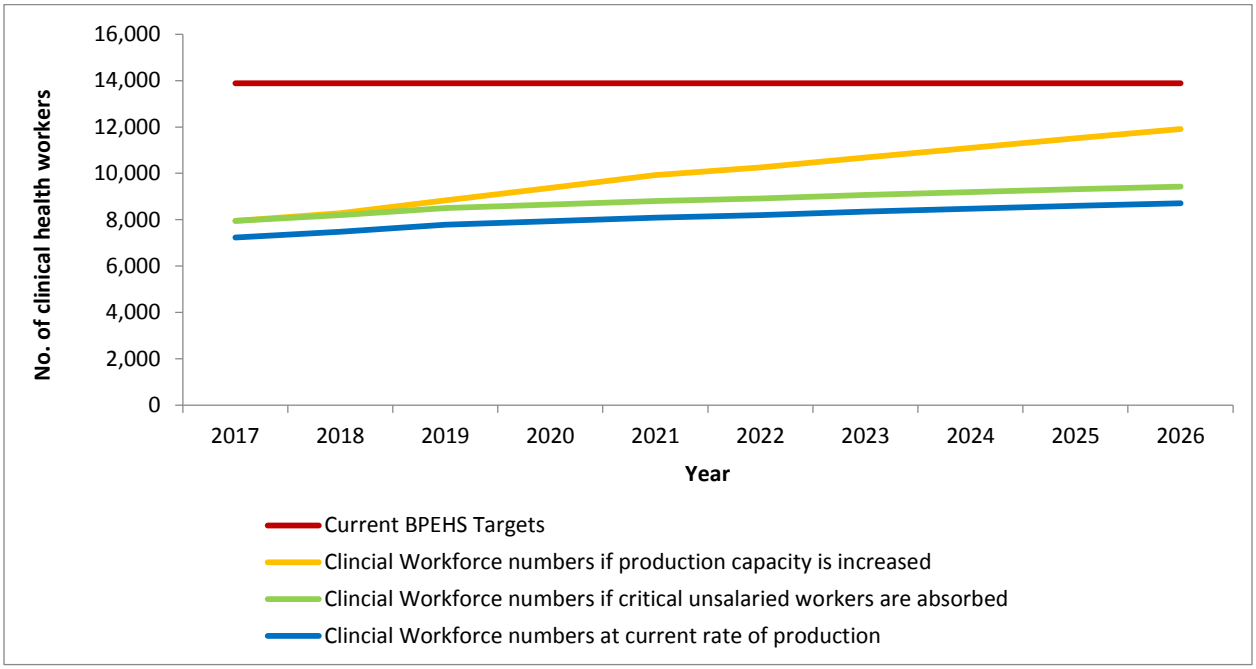
Note: In addition to the above, the CHW policy that has been finalised by the Directorate of Primary Healthcare implies a training budget of USD 5-7 million (SLL 36 -50 billion) in 2017 as induction training costs, with USD 1.2 million (SLL8.6 billion) for refresher training in subsequent years.

Outputs

a. Lowering of critical workforce gaps

The increases in production capacity described in the previous section would contribute significantly to reduction of existing gaps in the clinical workforce in country. The figure below illustrates how the government health workforce is projected to develop over time at the current rate of production compared to at the increased production rate described in the previous section, and compared to the scenario in which critical unsalaried workers are absorbed.

Figure 7. MoHS clinical workforce projections 2017-2026



At the current rate of production, absorption and attrition the overall clinical workforce numbers are expected to reach 63 % of target levels by 2026 (from current level of 52 %). The addition of critical unsalaried workers to the workforce (refer activity 1.2.1) will add approximately 5 % to the workforce number.

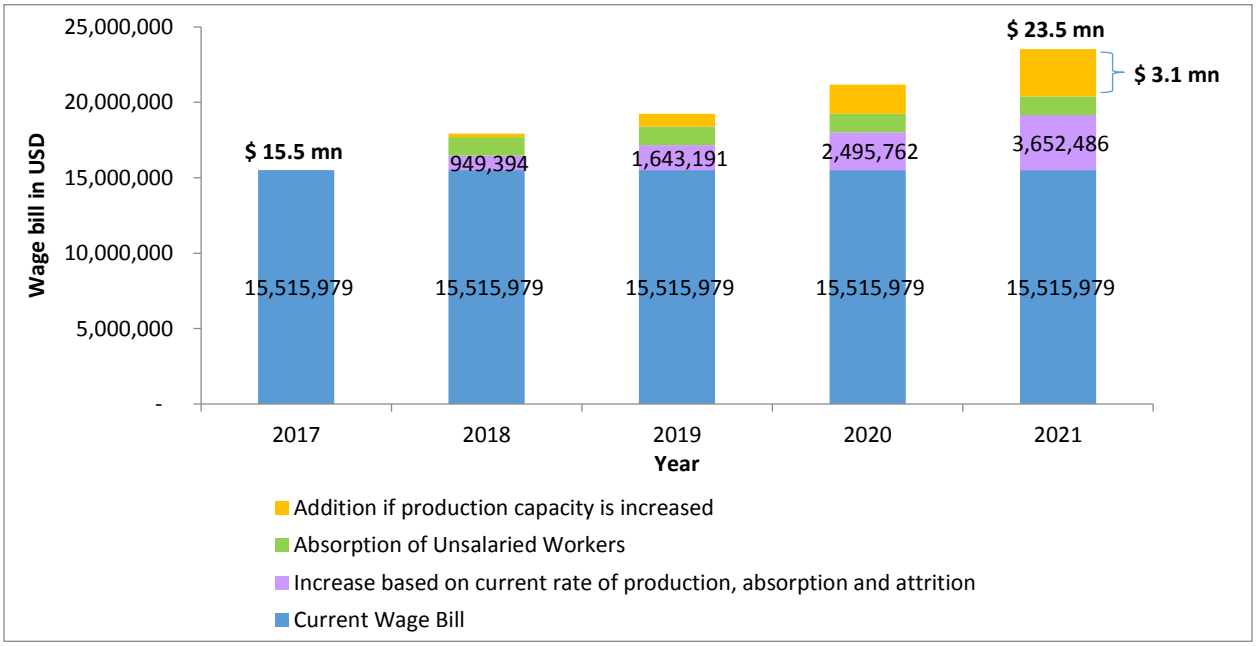
However, it is expected that by 2026, the clinical workforce will reach 86 % of target numbers if investments in production capacity are made in line with the estimates outlined in the previous section. This includes an increase of 9 % in Medical Officers, 125 % in SRNs, 160 % in midwifery cadres and 75 % in Pharmacists.

b. Increase in GoSL wage bill

With existing production capacity and an assumed absorption rate of 70 %, the current MoHS wage bill of USD 15.5 million (SLL 111 billion) on clinical workers is projected to increase to USD 19.1 million (SLL 137 billion)[30] by 2021.[31] Implementation of the HRH strategy 2017-2021 will lead to additional growth of the wage bill, driven by two key components:

a. Investments in the production capacity will add to the upward pressure on the wage bill as more health workers are produced and absorbed.
b. A decision to absorb currently unsalaried health workers in critical cadres will see an expansion of the payroll.

Figure 8. Clinical MoHS wage bill projection for clinical cadres for 2017-2021



The clinical wage bill expected to reach USD 23.5 million (SLL 169 billion) by 2021. This includes USD 1.2 million (SLL 8.8 billion) on absorbed unsalaried workers and USD 3.1 million (SLL 22.3 billion) on recruitment of health workers resulting from production increases, in addition to the natural growth of the wage bill based on past trends.

Note: Outside of the GoSL wage bill, the Directorate of Primary Healthcare has envisaged an expansion of the Community Health; however, the nature of integration of CHWs to the existing GoSL health workforce is being discussed by GoSL at the time of preparation of this report. Remuneration (including logistics reimbursements) for the CHW workforce is expected to cost approximately USD 5 million (SLL 36

[30] *This is assuming a freeze in absorption of SECHNs by 2018*

[31] *Assuming an annual attrition rate of 6.5%*

billion) in Year 1, assuming that approximately 13,000-15,000 CHWs will be enlisted under the National CHW program.

2. Other costed interventions under Objective 2

In addition to the main cost drivers, the assumption used for costing other interventions under Objective 2 are summarised in the table below.

Table 11: Assumptions for costing of interventions under Objective 2

#	Activity	Assumptions	Cost
2.2	Plan and implement interventions in pre-service training to increase the number of health workers in areas where addressing shortages is critical to meeting the country's health needs	It is assumed that revising the community-level cadre scopes of practice, defining new staffing norms and setting production targets will entail costs on workshops, meetings and on external consultants.	SLL 475 million / USD 66,000
		Conducting assessments and quantifying needs of targeted health training institutions, prior to making investments in health training institutions, entail costs on verification visits by a team of MoHS or external consultants.	SLL 259 million / USD 36,000
2.3	Strengthen pre-service training quality assurance	Developing standards and assessment tools for quality assurance of academic health education requires external technical assistance	SLL 324 million / USD 45,000
		It is assumed that developing and strengthening clinical curricula entail costs on technical assistance as well as on observation visits to training institutions	SLL 583 million / USD 81,000
2.4	Implement interventions to improve clinical training and practice sites	This has been costed in the National IPC policy and includes costs on IPC training, procurement of supplies as well as on screening and procurement of drugs for vaccinations.	SLL 21 billion / USD 2,900,000
2.5	Develop and implement a plan for standardised clinical mentoring and supportive supervision programmes and practices, focusing on the nursing and midwifery workforce	Costs assumed for piloting a clinical mentoring and supportive supervision programme with central and regional participation primarily entail costs on supervision visits and logistics.	SLL 309 million / USD 43,000

2.6	Strengthen coordination and monitoring of in-service training programmes, to improve cost-effectiveness and alignment with MoHS priorities while also enabling future CPD programs	It is assumed that establishing structures and processes, at central and district levels, to monitor and coordinate in-service training programmes requires technical assistance as well as increasing internal capacity of the Directorate of HRH.	SLL 936 million / USD 130,000

Objective 3

The assumptions for costing of interventions listed under this section are summarised in the table below.

Table 12. Assumptions for costing of interventions under Objective 3

#	Activity	Assumptions	Costs
3.1.	Staff and strengthen MoHS directorates to enable effective workforce planning and management	The rolling out of Integrated Performance Assessment System (IPAS) contributes significantly to the costs of this activity. The assumed cost drivers include: - Costs of Pilot in 1 District, including professional fees for external consultants - Roll–out in all districts including recurring supervisory visit by a central level team - Setting up of central level IPAS coordination team	SLL 3.45 billion / USD 480,000
		Developing revised functions for the Directorate of HRH to implement the HRH Strategy and implementing a staffing plan, entails costs of external evaluation to assess capacity gaps and additions to the internal HR capacity of the Directorate (13 new positions).	SLL 940 million / USD 130,600
3.2.	Develop and implement strategies and policies to decentralise human resources management functions at district level	The recruitment and deployment of 25 District level-HR officers contributes significantly to the costs of this activity. The assumed cost drivers include: - Training and sensitisation costs - Basic office infrastructure and equipment - Salary costs	SLL 2.3 billion / USD 330,000
3.3.	Strengthen HRH information communication to and from all levels	The sub-activities contributing to these costs include: a. Implementation of m-Hero (mobile tool for communication to health workers) which includes costs training costs, telecom service costs and costs of technical consultants to support implementation. <u>Note:</u> *This activity is already funded.* b. Printing and logistics costs associated with periodic dissemination of HRH bulletin to health workers and other stakeholders	SLL 2.7 billion / USD 387,000

3.4.	Strengthen regulatory agencies to manage the performance of health workers and health professional training programmes	The major cost drivers for this sub-activity include: - Professional fees associated with assessment of existing regulations and regulatory bodies, and the technical assistance required to strengthen existing regulations - Investment in IT enablement of existing process with a focus on records management	SLL 2.2 billion / USD 311,000

Objective 4 and Objective 5

These objectives do not entail significant investment as these can be undertaken using the existing capacity within MoHS.

Appendix 3: Composition and focus areas of Technical Committees

Table 13. Composition and focus areas of Technical Committees

Subject	*Chair/Co-Chair, Facilitator*	*Members*	*Topics*
Pre-service training, in-service training, regulation and service delivery	*Chair: Deputy Chief Medical Officer 1* *Dep. Chair: Coordinator Post-Graduate Medical Training* *Co-Chair: WHO* *Facilitator: CHAI/WHO*	• Cadre leads • Health Training Institutions • Ministry of Education, Science and Technology (MEST), Tertiary Education Committee (TEC) • Regulatory boards • DHRH/MoHS • Health Service Commission (HSC) • King's Partnership Sierra Leone • Liverpool School of Tropical Medicine • College of Medicine and Allied Health Sciences (COMAHS) • Center for Disease Control (CDC) • Partners in Health • Health Alert • ICAP, Columbia University	• *Workforce targets* • *Alignment of Scopes of Practices* • *Training curricula and accreditation* • *Training capacity* • Regulation • Clinical training environment • Service delivery quality assurance • Working environment • In-service training and continuous professional development (content)
Financing and planning	*Chair: HSC* *Co-Chair: Director of Internal Audit, MoHS* *Facilitator: CHAI*	• Ministry of Finance and Economic Development (MOFED) • MEST • Human Resource Management Office (HRMO) • HSC • DHRH/MoHS • Donors • Local Councils • Voluntary Services Overseas • Public Service Commission (PSC) • Community Health Worker (CHW) hub • Integrated Health Projects Administrative Unit (IHPAU)	• *Coordination between MoHS, MoFED, MEST and local councils* • *Make workforce planning and production evidence-based, stable and transparent* • *Medium-term expenditure framework for health workforce, including long-term financial sustainability* • *Coordination of partner contributions*
Management and leadership	*Chair: DHRH* *Co-Chair: UNFPA* *Facilitator: CHAI*	• HRMO • HSC • DHRH/MoHS	• Planning, deployment and transfer processes • Recruitment process (not

	• DHMTs • Local councils • Cadre leads • CUAMM – Doctors with Africa • WHO	financing) • Motivation and retention • Remuneration • Performance appraisal and discipline • Information systems • Decentralisation of management • Coordination of in-service training

Appendix 4: International best practices and evidence

This section summarises best practices and successful examples from other countries and the associated lessons learned that have informed the Sierra Leone HRH Strategy 2017-2021.

- **Community health should be a focus area in health education to strengthen care in remote/rural settings**. Given the demography of Sierra Leone with large populations living in remote/rural area, it is important to ensure that health workers are well-prepared and well-integrated into the health system to provide services. Successful examples from other countries include:
    - In Malawi, approximately 25% of the curriculum's contact hours were dedicated to community health to ensure that health workers are exposed to what it entails to work in a remote/rural setting with students gaining valuable experience learning to prevent, diagnose, and treat diseases more prevalent in Malawi and affect the poorer communities.

- **Training plans should be developed in close collaboration with the ministry responsible for higher education as well as regulatory bodies.** A successful implementation of a training plan requires collaboration between the mentioned agencies and therefore needs to be developed in the same collaboration to ensure ownership and engagement. Successful examples include:
    - In Kenya, effective ongoing collaboration and partnerships between MoHS, MEST, training institutions and regulatory/accreditation authorities on a specific health workforce strategic plans were very instrumental in enhancing the production of health workers

- **Accreditation and quality measurements are important to standardise training and capabilities, and a way to leverage benefits from growth of private institutions in medical education.** The presence of quality assurance mechanisms may allow for the development of a more effective mix of public and private sector education providers by licensing only those that meet accepted standards. In addition, measures should be put in place to move from a single lifetime registration/licensure to periodic re-licensure linked to evidence of continuous professional development (CPD) and/or re-assessment of competence to practice.

- **'Home-grown' solutions to healthcare financing are often more successful.** Developing and piloting country-specific solutions ensures country ownership and reduces dependence on donor funding, e.g. trust Funds that pull funds and revenues from multiple sources. Successful examples include:

- In Zimbabwe, the National AIDS Trust Fund was financed by a levy of 3% on the taxable income of individuals and firms
- In Tanzania, the government is working to establish an AIDS Trust Fund that draws funds from a ring-fenced budget, which will be established by the government and other sources, such as foreign and local private donations and investment incomes
- Uganda has proposed to establish a HIV Trust Fund to provide sustainable financing for HIV programmes

- **A well-functioning HR information system (HRIS) is critical to provide the required data for effective and efficient HRH planning**: Such information systems provide the foundation for strong workforce planning, development, and management including recruitment, deployment, retention, quality assurance and productivity. The evidence further points to the need to replicate these at the district level to support districts to keep records and regularly update the central HRIS database.

- **Commitment should be shown towards utilising CHWs in bridging health service delivery gaps, particularly in rural communities:** Ensuring that CHWs are considered in HRH planning and that efforts are made to enhance their performance, e.g. by ensuring supplies and equipment, strengthening referral systems and supervision, ensuring regular and sustainable remuneration packages, will ensure that CHW scale-up efforts are conducted in-sync with efforts to strengthen linkages with other health cadres in the health system for better efficiency and sustainability.

- **Decentralising HRH management has the potential to improve health worker motivation and retention:** Central and consequently lengthy recruitment processes are shown to have negative impact on motivation and retention. Successful decentralisation requires political commitment from local government leadership and clearly defined roles and responsibilities. Further, administrative and managerial capacity at the local level often needs strengthening to enable planning, budgeting, implementing and monitoring.

- **Rural retention strategies should be introduced as a comprehensive package:** Evidence is stronger for all-encompassing retention packages than for isolated retention interventions. Examples of components of such packages include:
  - Specific tours of duty (e.g. 2 years), which are respected
  - Preferential training access for those working in rural areas
  - Provision of housing close to facilities (especially for female staff)

- **Financial incentives, as well as quality of clinical supervision, peer support and adequate recognition for achievement are critical components to overall health worker retention:** Overall retention should be addressed through a package of strategies. As for financial incentives, reintroducing the PBF should be considered as well as the need to address challenges with financial top-ups.

The table below outlines additional international evidence to be considered as the Sierra Leone HRH landscape evolves.

Table 14. Examples of HRH best practices from other countries

Initiative/ Intervention	*Evidence on best practices and successful examples from other countries*	Lesson learnt internationally
Educational reforms	The CapacityPlus project in Nigeria undertook an assessment of Nigerian midwifery, health technology, and nursing schools to further elucidate progress and challenges in producing greater numbers of competent and qualified health providers.	Conducting performance needs assessment of the health training institutions can help in understanding their production capacities hence help in devising mitigation strategies where there are capacity gaps
	Medical Education Training Partnership Initiative (MEPI) awarded grants to African institutions in a dozen countries, forming a network including about 30 regional partners, country health and education ministries, and more than 20 U.S. collaborators.	It is important to form international partnerships to enhance the training of health workers, giving the opportunity for countries to learn from each other's experiences and best practices
Workforce planning	In Malawi, little difference was found in patient outcomes between childcare provided by medical assistants and that provided by doctors	Mid-level health workers can be empowered to provide supervision to lower skilled health care workers such as SECHNs and CHWs, depending on the country dynamics.
	In Mozambique, nurses with five years' experience, upon acquiring further training, transitioned as surgical/obstetric officers, capable of performing caesareans in the absence of a doctor, which had a positive impact on the maternal health crisis.	Strategies for task-shifting are most effective when they are embedded in effective systems of education, training, supervision and referral
Continuing Professional Development/In-Service Training	The Pharmacy board in Sierra Leone has a non-formal CPD as a precondition for the renewal of licenses. Measures are underway for formalising this process that will enhance practice and improve on overall health outcomes	A formalised and accredited CPD programme is needed to continuously address the skills and competency gaps for effective service delivery.

Innovative sustainable financing of health - Public-private partnerships	The Abbott Fund and the Government of Tanzania formed a public-private partnership to strengthen the country's health care system and address critical areas of need. The Abbott Fund has invested more than USD 100 million in this partnership effort, which has lasted more than 10 years. In addition, the Abbott Corporation has made more than USD 5 million in corporate donations to the health sector	The development of public- private partnerships to regulate and attract investments in the health sector can be a sustainable source of health financing.
	The Government of Kenya through private-public partnerships (PPPs) initiatives issued bonds to finance its HIV budget.	
Innovative sustainable financing of health - Health insurance	Rwanda and Ghana introduced *"contributory schemes"* where every household is expected to contribute to an insurance scheme. Ghana introduced a National Health Insurance levy of 2.5% on certain goods and services.	A sustainable health insurance scheme ensures universal health coverage and reduces out of pocket spending
	In Kenya, a viable source of domestic funding for health comes from the National Hospital Insurance Fund which is compulsory for all formal sector employees and optional for informal employees.	
Community Health Workers – Scale up efforts	Malawi developed an intra-MOH collaboration strategy, which allowed different directorates of the MOH to be involved in reviewing community health guidelines, thereby ensuring inclusion of CHW activities into various programs within the MOH	Inter and intra ministerial collaboration at all levels is critical to a successful and sustainable community health program.
	Rwanda has made great strides in harmonising CHW programs by developing policies that strengthen coordination of community health services at all levels across the health system	Proper coordination is necessary for the effective planning recruitment and deployment of CHWs, while ensuring their actions complement those of other interventions in the community.