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Evaluation of DFID Support to Healthcare Workers Salaries in Sierra Leone

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Contents

Acronyms and abbreviations 1
Executive summary 2
1 Background and Methodology 6
1.1 Introduction 6
1.2 Background 6
1.3 Evaluation method 7
2 Key findings 9
2.1 Process evaluation 9
2.1.1 DFID Theory of Change 9
2.1.2 Strength of the evidence base 11
2.1.3 Gaps or weaknesses in the evidence base 12
2.1.4 GF decision-making around support to healthcare workers salaries 13
2.1.5 DFID and GF processes for transferring funds to Government 13
2.1.6 MoHS leadership and ownership 14
2.1.7 Involvement and ownership of other implementing ministries 14
2.1.8 DFID technical advice to Government 15
2.2 Impact evaluation 16
2.2.1 Salary uplift to healthcare workers 16
2.2.1.1 Impact of salaries uplift on health outcomes for target groups 16
2.2.1.2 Impact of DFID contribution to salaries uplift on health outcomes 18
2.2.1.3 Impact on charging of user fees 20
2.2.1.4 Impact of other factors affecting formal & informal remuneration 22
2.2.2 Payroll improvement 25
2.2.2.1 Status of the payroll 25
2.2.2.2 Estimated savings accruing to Government 28
2.2.2.3 Effectiveness of systems for payroll management 29
2.2.2.4 Access to the payroll by new joiners 29
2.2.2.5 District level support for the payroll system 29
2.2.2.6 Effectiveness of central MOHS systems and new HSC 30
2.2.2.7 Lessons from comparable countries 31
2.2.3 Attendance monitoring 32
2.2.3.1 Effectiveness of the AMS In incentivising healthcare workers 32
2.2.3.2 Effectiveness of the AMS In sanctioning non-attendance 33
2.2.3.3 Sustainability of the current system 33
2.2.3.4 Improvement in attendance and health outcomes 35
2.2.3.5 Effectiveness of PSC in overseeing the AMS 36
2.2.3.6 Effectiveness of the PSC results framework 37
2.3 Monitoring and evaluation 37
3 Conclusions 38
4 Recommendations 40

Annexes ... 41
Annex 1 Terms of Reference ... 41
Annex 2 Documents reviewed ... 48
Annex 3 Evaluation workplan ... 50
Annex 4 DHMTs and District Councils questionnaire ... 52
Annex 5 Health facilities questionnaire ... 58
Annex 6 Exit Survey Questionnaire ... 62
Annex 7 Payroll data collection tool ... 63
Annex 8 Stakeholders interviewed ... 67
Annex 9 District level interviews ... 69
Annex 10 Trends in service utilisation ... 70
Annex 11 Results from the exit survey ... 76
Annex 12 Performance indicators July 2012 ... 82
Annex 13 Governance structures ... 83
Annex 14 Health Services Commission ... 84
Annex 15 Risk and mitigation matrix ... 86

Tables

Table 1: Reason for not accessing assistance from health facility ... 11
Table 2: Historic health impact indicators ... 17
Table 3: Utilisation data at the national level 2009 - 2011 ... 18
Table 4: Respective contributions of GOSL and external partners to the cost of salaries ... 20
Table 5: Options for medium term support for payroll and AMS ... 34
Table 6: Future cost of healthcare worker salaries to GoSL ... 35

Acronyms and abbreviations

AGD	Accountant Generals Office
AMS	Attendance Monitoring Systems
CGA	Charlie Goldsmith Associates
DFID	UK Department for International Development
DFID SL	DFID Sierra Leone
DHMT	District Health Management Teams
DHQ	District Headquarters
DHS	Demographic and Health Survey
DMO	District Medical Officer
DPI	Department of Planning and Information, MoHS
DSA	Daily subsistence allowance
FHCI	Free Health Care Initiative
GFATM/GF	Global Fund for TB, Malaria and AIDS
GoSL	Government of Sierra Leone
HFAC	Health for All Coalition
HRH	Human Resources for Health
HRH SU	Human Resources for Health Support Unit, MoHS
HRIS	Human Resources Information Systems
HRM	Human Resources Management
HRMIS	Human Resources Management Information Systems
HRMO	Human Resources Management Office
HSC	Health Services Commission
ICT	Information Communication and Technology
IFMIS	Integrated Financial management Systems
IPPS	Integrated Payroll and Personnel Systems
JPWF	Joint Programme of Work and Funding
LFM	Logical framework matrix
MCH	Maternal and child health
M&E	Monitoring and evaluation
MICS	Multiple Indicator Cluster Survey
MoFED	Ministry of Finance and Economic Development
MoHS	Ministry of Health and Sanitation
OECD-DAC	Organisation for Economic Cooperation and Development – Development Assistance Committee
PBF	Performance based funding
PM	Programme memorandum
PSRP	Public Sector Reform Programmes
PSC	Payroll Steering Committee
RCH	Reproductive and child health
RHQ	Regional Headquarters
TA	Technical assistance
ToRs	Terms of reference
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Childrens Fund
WHO	World Health Organisation

Executive summary

The Government of Sierra Leone (GoSL)s 'Free Healthcare Initiative'(FHCI) was launched in April 2010 to increase access to key healthcare services by removing user fees for priority groups, specifically, pregnant women, lactating mothers, and children under five.

The Department for International Development Sierra Leone (DFID SL) responded by providing support to GoSLs in a number of areas including, at the request of GoSL, providing significant financial contributions to increase healthcare worker salaries up to an acceptable level in order to reduce the incentive for healthcare workers to continue to charge for services. DFID SL has budgeted £10.3m to support higher salaries for healthcare workers over a five year period. This is front loaded based on the assumption that the Government will progressively increase its share of the increased cost. The financial aid to GoSL through this programme is subject to certain conditions between DFID SL, the Ministry of Health and Sanitation (MoHS) and the Ministry of Finance and Economic Development. The Global Fund (GF) have also joined DFID SL in supporting GoSL to meet the cost of higher salaries subject to performance against joint indicators and benchmarks, in a partnership which is formalised in a Memorandum of Understanding between the three parties.

This independent evaluation of the programme 'Support to Healthcare Workers Salaries in Sierra Leone' was commissioned by DFID SL to evaluate the impact of its support to the healthcare worker salary programme. The inception phase comprised the review of programme documents which identified a critical issue regarding the lack of information on whether fee charging is continuing at health facilities. It was subsequently agreed that a number of patient exit surveys would be included in the data collection process at facility level. Data collection comprised a series of interviews with DFID SL and their technical advisors, GoSL officers and other partner stakeholders in addition to a series of field visits. 7 Districts in 3 Regions participated in the evaluation and 34 district stakeholder interviews were undertaken. A total of 21 health facilities were visited where interviews focused on the collection of data on user fees, service utilization, as well as payroll and HR data. In addition 218 exit interviews were undertaken by monitors from the Health for All Coalition (HFAC) who accompanied the evaluation team during the field visits. The team attended the Payroll Steering Committee meeting in addition to presenting their preliminary findings at a stakeholders de-brief meeting that concluded the mission.

Prior to the DFID SL intervention the GoSL payroll was acknowledged to be grossly inaccurate. Staff numbers, job designations and workstations were known to be incorrect in many cases, there were many 'ghost-workers' on the payroll and the heavy reliance on 'volunteers' to provide health services distorted any picture of the actual numbers of healthcare workers across the sector and even basic staffing establishment and staff in-post data was known to be inaccurate. Similarly there was no robust evidence of the extent of formal and informal fee charging.

While it is currently not possible to measure impact on health outcomes in the absence of any population based sample survey of mortality rates since April 2010 when FHCI was implemented, it is feasible to measure attainment at the programme purpose level, which is "to increase the uptake of health care by the most vulnerable". Data at national level from the HMIS indicates an initial steep increase after the announcement of the FHCI in April 2010 in utilisation of maternal and child health services, with a slight decline in the last quarter of 2010. In 2011 there was a considerable fall in under-five attendances, though not to the level of 2009, while

maternity related services showed a slight upwards trend. The setback in 2011 is thought to be related to disruptions in drug supply, since corrected, but data for the first 2 months of 2012 does not suggest reversion to the high levels of utilisation found in 2010.

A critical success of FHCI is that the majority of patients in the target groups now benefit from access to free healthcare – this has to be recognised as a major achievement in the relatively short timescale since the initiative was introduced. However, improper charging of some patients entitled to free health care continues and, although the scale of this practice cannot at this point be fully determined, the exit survey undertaken as part of this evaluation provides a ‘snap-shot’ suggesting that as many as 20% of FHCI beneficiaries attending GoSL facilities are required to make some level of payment. Despite these findings, district and facility staff interviewed were insistent that improper charging does not occur and consistently reported that FHCI was being fully implemented. There is no evidence that those staff members known to be participating in improper charging are ever sanctioned.

This situation is exacerbated by the poor regulation of formal user fees. Whilst healthcare workers are legitimately able to charge non-target groups for cost-recovery drugs, the lack of regulation about what fees can and cannot be legitimately charged across the health sector as a whole acts as an enabler for the improper charging of those patients who should be beneficiaries of FHCI. Similarly, the difficulties in ensuring adequate drug supplies at facility level - of both free FHCI drugs but also cost-recovery drugs – is another factor which is used as justification for improper charging. Based on the interviews undertaken during the field visits the evaluation team were unable to establish whether or not there was any link between the increase in healthcare workers’ salaries and reduced fee charging.

However, there has been tremendous improvement in the quality of MoHS payroll data and its management. The data is accurate and reliable (numbers and payroll amounts) and shared by MoHS, HRMO and AGD which facilitates workforce planning. The monetary savings from the first round of pay freezes aimed at eliminating ghost workers are calculated at US$408,200 over the 27 month period March 2010 to May 2012, according to MoHS reporting. Close monitoring and strong management arrangements, put in place under the direction of the Payroll Steering Committee (PSC), have resulted in greater confidence that ghost workers have been eliminated from the payroll, the number of staff on the payroll reporting to their workstations has increased and staff are being paid at the contracted grade. The timeliness of payroll amendments has improved significantly – although pressures remain when large numbers of amendments are required, for example following the recent recruitment drive – but this is a major improvement compared to previously when staff were working for months, or even years, as volunteers without being formally paid through the GoSL payroll.

Attendance monitoring has also improved. A functional attendance monitoring system is now in place which is simple, well understood and is easily implemented at facility and district levels. The sanctions for non-attendance are also well-understood at all levels and sanctions are being imposed and salaries withheld for non-attendance in line with the Conduct and Sanctions Framework. However some Districts are still reporting high levels of staff with unauthorised absence[1], warranting further investigation by the PSC.

[1] For example the MoHS attendance summary for March 2012 shows some Districts reporting 10% of staff as unauthorised absence.

Monitoring attendance at facility level remains challenging in remote locations and difficulties associated with ensuring adequate monitoring and supervision of facilities with only one or two staff, provide opportunities for misreporting of attendance. The decision to involve civil society in monitoring health sector performance is a very positive way forward, however there is a heavy reliance on community and civil society organisation engagement in monitoring attendance and fee-charging, in particular on HFAC which has limited resources and capacity to fulfil its mandate fully.

The PSC has played an important role in embedding the salary uplift and the engagement of all senior level stakeholders via their membership of the Committee has helped to foster ownership and commitment. It also provides a useful mechanism for strengthening GoSL capacity for performance management and cross-Ministry collaboration.

Although the monetary savings from improved payroll management and attendance monitoring systems are not insignificant, the larger benefit of the payroll reforms is the motivation they have provided for the publicly financed workforce to be present and on time. Compared to the totally unregulated situation which existed previously, currently the health workforce is predictably present on duty and understands that unauthorized absence will no longer be tolerated. There is greater confidence in the accuracy of the payroll and this now provides a solid basis for better human resource management and workforce planning.

The evaluation has identified a number of challenges related to the payroll system, including: (i) the current capacity of the Human Resources for Health Support Unit (HRH SU) in the MoHS; (ii) inadequate infrastructure; (iii) systems security and (iv) the limitations of the systems for wider HRH data management.

In terms of sustainability, interrogation of the data provided by GoSL indicates that the salary uplift is financially sustainable in line with the agreed GoSL, DFID SL and Global Fund funding arrangements The payroll management and attendance monitoring systems are also sustainable in principle but there are some concerns about the capacity of the HRH SU to maintain the system if there are any technical issues or if the Units' workload increases as is likely when it becomes more involved with the development of the new HRMIS.

What can be said with confidence is that the salary uplift was critical to the success of the FHCI thus far. Prior to March 2010, the GoSL health workforce was functioning at a very low level of commitment, with high absence rates and the constant distraction of the search for additional income. At that time a strike of health workers was threatened in protest at their low wages. The announcement of greatly enhanced salary scales had an immediate effect in attracting new recruits and changing the incentive structure for existing employees. DFID SLs decision to support the salary uplift was also catalytic in the sense that it leveraged much larger contributions from GoSL and GF.

Although the evaluation has identified a number of challenges that remain in regard to successful implementation of FHCI, it is evident that considerable progress has been made in a relatively short time frame. However the programme emphasis on strengthening management of the payroll and attendance monitoring, has potentially distracted from other critical enabling factors for the success of the FHCI, such as the removal of user fees and tackling improper charging in order to increase service utilisation, which are fundamental to DFID's theory of change. The scope of the

ToRs for this evaluation focuses primarily on payroll management and attendance monitoring. The 4-year impact evaluation, commissioned by DFID SL and commencing in the coming months[2], has a wider scope which considers the impact of interventions on the elimination of user fees and improper charging, increased service utilisation and the quality of service provision.

[2] These recommendations are already in incorporated in the TORs for the FHCI impact evaluation. The contract for the evaluation was signed and work commenced in late July 2012, shortly after the conclusion of this assignment.

1 Background and Methodology

1.1 Introduction

This independent evaluation of the programme 'Support to Healthcare Workers Salaries in Sierra Leone' was commissioned by the UK Department for International Development, Sierra Leone (DFID SL) to evaluate the impact of its support to the healthcare worker salary programme. It takes place at roughly the mid-point of the programme and its purpose is to inform DFID SL on the extent to which its 'theory of change' and intervention logic has proved correct; and to understand the magnitude of the impact of its intervention to date. The evaluation was undertaken in June and July 2012. Terms of reference (TORs) for the evaluation are attached at Annex 1.

1.2 Background

DFID SL has been a major supporter of the Government of Sierra Leone's (GoSL) policies to improve healthcare outcomes for poor Sierra Leoneans. Given Sierra Leone's high maternal and child mortality rates and uncertain progress towards relevant Millennium Development Goals, rapidly improving healthcare outcomes is considered a priority. The 2008 National Service Delivery Perception Survey indicated that the most significant barrier to accessing healthcare was cost of services, while the Programme Memorandum (PM) refers to comparative research findings suggesting that healthcare workers in Sierra Leone were significantly underpaid relative to their peers in comparable countries. GoSL's launch of the 'Free Healthcare Initiative'(FHCI) in April 2010 represented a major step forward in increasing access to key healthcare interventions for mothers and young children. GoSLs key response to the issue of access was to remove user fees for priority groups, identified as pregnant women, lactating mothers, and children under five – while at the same time increasing the salaries of healthcare workers.

To support the government, DFID SL provided policy advice through technical assistance to implementation, significant financial support in the form of drug purchases to meet anticipated increased demand, and contributions towards increasing healthcare worker salaries to an acceptable level as a strategy to reduce the incentive for healthcare workers to continue to charge for services.

DFID has budgeted £10.3m to support higher salaries for healthcare workers over the five year period August 2010 to February 2015. Support is front loaded based on the assumption that the Government will progressively increase its share of the increased cost. Financial aid to Government through this programme is subject to certain conditions between DFID, the Ministry of Health and Sanitation (MoHS) and the Ministry of Finance and Economic Development (MoFED); specifically, maintenance of the integrity of the payroll, and performance against a set of indicators and benchmarks jointly agreed between DFID, the MoFED, the MoHS and the Human Resources Management Office (HRMO). The Global Fund (GF) have also joined DFID in supporting the Government in meeting the cost of higher salaries for healthcare workers subject to performance against the same indicators and benchmarks.

Alongside financial support for a better paid healthcare workforce, DFID has also made a significant investment in improvements to the payroll management of the workforce.

1.3 Evaluation method

DFID has re-energised its approach to improve the organisation's use of evidence to deliver results and defines an evaluation in line with the OECD/DAC guidance. The TORs provide a comprehensive list of evaluation questions relating to both 'process' and 'impact' evaluation (specifically salary uplift to healthcare workers, payroll improvement and attendance monitoring). The evaluation explores all questions raised in the TORs within the OECD-DAC evaluation framework of relevance, efficiency, effectiveness, impact and sustainability, consistent with DFID's approach to evaluation. The evaluation has four stages: inception, data collection, report preparation and dissemination.

The inception phase comprised an independent review of programme documents supplied prior to commencement of the in-country work; additional documents were reviewed during the in-country mission. A full list of the background documents reviewed is attached at Annex 2. A work plan for the evaluation was also developed as part of the inception phase and is attached at Annex 3. A number of draft data collection tools were developed and these are attached at Annexes 4 – 7. These tools provided a framework for the collection of qualitative and quantitative data via a series of interviews with representative from key stakeholders. During the documentation review the evaluation team identified a critical lack of information on whether fee charging is continuing at health facilities and it was subsequently agreed that a number of patient exit surveys would be included in the data collection process at facility level.

Week one comprised a series of interviews with DFID SL technical advisors, GoSL officers and other partner stakeholders. Interview topics were tailored for each stakeholder in order to ensure breadth of feedback and make the process less onerous for interviewees, while ensuring sufficient data was obtained to answer the evaluation questions. A list of the stakeholders interviewed during the mission is attached at Annex 8.

During week two field visits were undertaken by the evaluation team with DFID providing guidance on how best to schedule activities in order to make the most effective use of available time and resources. Three regions were visited and a number of districts within each region. To elicit perspectives from a range of District Councils and District Health Management Teams (DHMTs), 34 district level stakeholder interviews were conducted. A number of health facilities were visited within each district to interview healthcare workers and service users, and included both urban and rural locations given that the documentation review suggested an inequity of health service provision between rural and urban areas, and in particular challenges relating to incentives of rural health workers. The facility visits included the District Hospital and at least two Peripheral Health Units (PHUs) in each district. A total of 21 facilities were visited. At facility level the interviews focused on the collection of data on user fees, service utilization and payroll and HR data. Where possible additional data was also collected on other factors known to affect service provision, for example availability of drugs supplies and equipment, catchment populations, geographical challenges and facility conditions. A list of the facilities visited is attached at Annex 9.

In addition, a number of patient exit interviews were undertaken by monitors from Health for All Coalition (HFAC) who accompanied the evaluation team on the field visits. A total of 218 exit interviews were conducted.

Preliminary analysis of the payroll, HR and exit survey data commenced in week three and several critical stakeholder meetings that could not be scheduled during the first week also took place during this week. The evaluation team attended the Payroll Steering Committee meeting and also presented preliminary findings at the stakeholders de-brief meeting that concluded the mission.

Limitations

The ToRs note that the increase in healthcare worker salaries was a nationwide event affecting all publicly employed healthcare workers at the same time. As a result, it is not possible to undertake a control-intervention site comparison of impact. Whilst recognising that DFID's front-loading of its support was critical to commencing the FHCI there is a problem of attribution because (a) the DFID contribution to enhanced salaries at around 20% is relatively small and (b) there are so many intervening variables, in particular the impact of non-salary variables on the quality of service, and consequential changes in utilization. At this stage in the implementation period, in the absence of current data comparable to the health status estimates produced by the Demographic and Health Survey (DHS) 2008, the evaluation team were able to produce evidence concerning 'outcomes' rather than 'impact', although some conclusions can be drawn about 'likely impact'.

The Inception Report identified a number of key stakeholders to be interviewed however the UNFPA focal person involved in this programme was out of the country during the evaluation period. Fortunately he returned in time to attend the stakeholder debrief meeting and was able to question the team on the preliminary findings.

Question (d) of the TORs asks 'How does DFID SL's theory of change and evidence base compare to that used in other DFID country offices undertaking similar programmes?' Discussions were held with the DFID Health Advisor during the evaluation period to identify comparable programmes and relevant documentation. Although DFID supports healthcare worker salaries in Malawi and Zambia it was concluded that these are not comparable to the programme being supported in Sierra Leone, however the evaluation team have reflected on these particular programmes as part of the evaluation.

2 Key findings

2.1 Process evaluation

2.1.1 DFID Theory of Change

a) To what degree has DFID's theory of change as stated in the Programme Memorandum been proved correct?

The original DFID SL programme of support was designed in 2008 prior to the launch of FHCI and originally focussed on supporting the GoSL implementation of the Reproductive and Child Health Strategic Plan 2008-2010. The launch of FHCI in 2010 FHCI identified 6 priority areas for GoSL aimed at ensuring:

1. Continuous availability of equipment, drugs, and other essential commodities;
2. Adequate number of qualified health workers;
3. Strengthened and effective oversight and management arrangements
4. Information, education and communication to stimulate demand for free quality health services;
5. Monitoring and evaluation;
6. Adequate infrastructure.

Once the FHCI was launched, GoSL requested DFID support for an uplift to healthcare worker salaries because the abolition of user fees that followed the launch of FHCI raised the issue of low pay amongst health staff, who were known to supplement their salaries through the charging of informal user fees. In addition, tackling low healthcare worker salaries was seen as an important factor for recruiting and retaining the healthcare workers needed to deliver the FHCI. DFID SL agreed to support this particular component of FHCI implementation – which was only one part of a wider package of development partner support for FHCI - on the assumption that without this the FHCI would be at risk. This decision to respond to GoSLs request required a significant reorientation of the original DFID SL programme. DFID SL acted quickly to re-focus its inputs and maximise support for GoSLs efforts to reduce maternal and infant mortality, which is entirely consistent with the original goal of the programme.

The rationale for the revised programme was based on the assumption that increasing healthcare worker salaries would remove the incentive to charge user fees for the target group, resulting in improved health outcomes[3]. The Programme Memorandum (PM) states that the focus of the programme is specifically on sustaining the removal of user fees for women and young children accessing health care, which is to be achieved by enabling GoSL to meet its commitment to raise the financial allocation for healthcare worker salaries to US$18 million/year. The other critical issue identified for successful and sustained removal of user fees was the provision of a sufficient supply of drugs and commodities to meet anticipated increased demand however DFID SL was already taking steps to address this through its funding to UNICEF for drug procurement. Tackling both of these critical issues together was seen as increasing the likelihood of successful implementation of FHCI.

The programme goal in the original logical framework matrix (LFM), was '*To reduce maternal and child mortality by ensuring user fees are not applied*' and the Purpose was '*To increase the uptake of health care by the most vulnerable*'.

[3] Programme Memorandum June 2010

The four outputs were:

1) Removal of user fees is sustained through a regularly paid salary uplift;
2) Payroll is kept clean and managed well by government;
3) Reliable and accurate information and data is generated enabling GoSL to monitor staff attendance and manage personnel deployment; and
4) The no user fee policy is fully implemented and where necessary enforced.

The LFM was amended in response to the recommendations of the 2011 DFID Annual Review and the revised goal of the programme is '*To support the successful implementation of the FHCI in order to secure health outcomes*'.

There are now three outputs in the current LFM[4]:

1) Health payroll effectively managed;
2) Enhanced capacity of MoHS to manage human resources for health with respect to attendance and deployment; and
3) Effective community oversight of FHCI by civil society.

Whilst the revisions to the logframe are entirely appropriate in light of changes to the context in which the programme is now being delivered they have resulted in a greater focus on payroll management and attendance monitoring at the expense of the initial focus on eliminating user fees, which is now no longer identified as a specific programme output as it was in the original LFM. This is important given that the theory of change is premised on the assumption that an increase in salaries will sustain the removal of user fees for women and young children accessing health care but the LFM no longer measures the extent to which user fees have removed. Progress in eliminating user fees for target groups thus far is detailed later in this report.

Although not explicitly stated in the PM, the Purpose level indictors imply an assumption that service utilisation (i.e. percentage of deliveries by skilled health provider; percentage of women receiving IPT; percentage of children treated with anti-malarial drugs) will increase as a result of planned programme outputs, and yet the LFM Outputs 1 and 2 relate only to improvements in payroll management and Output 3 refers to civil society monitoring of FHCI. There is no output that is specific to increased service utilisation. It is possible that the programme outputs could be successfully delivered, and all indictor targets met, without the programme Purpose being achieved.

Output 3 concerns effective community oversight of FHCI by civil society which is relevant to the programme Purpose and refers mainly to the role of HFAC which has a mandate to monitor healthcare worker attendance, availability of drugs and the absence of user fees. HFAC have a vital role in monitoring the uptake of services and they have benefitted from direct programme support to help build their monitoring and reporting capacity. However this support from DFID SL through Options ended in March 2012 and concerns remain about their organisational capacity, particularly in reporting. Evidence for reporting performance against Purpose level indicators 4-6 of the LFM relies heavily on HFAC reporting but at present the system for reporting is not yet functional in a way that allows DFID SL to clearly ascertain whether or not the relevant LFM milestones are being met. The evaluation team recommends that this is given further consideration because if HFAC are unable to produce appropriate reports the source of data for monitoring performance against Purpose level for drug procurement indicators 4-6 may have to be revised.

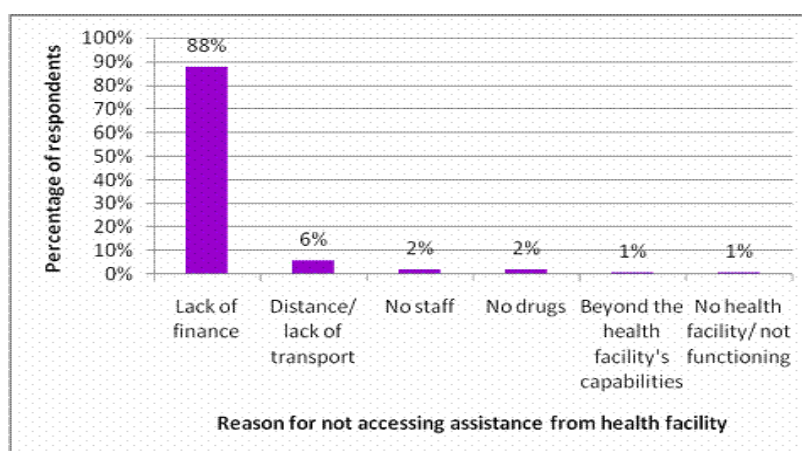
[4] It is noted that the ToRs for this evaluation identify the 4 Outputs from the original LFM (February 2009)

2.1.2 Strength of the evidence base

b) To what degree was the evidence that DFID SL used to justify and determine salary increases robust and valid?

The FHCI was launched in April 2010 as a response to the recognition that the cost, and/or perceived cost, of accessing care was the most significant reason in preventing the uptake of health services particularly by the most vulnerable: pregnant and nursing women and children under the age of 5. However the evidence to justify the salary increases is somewhat limited and the documents reviewed draw primarily on the findings of the 2008 National Service Delivery Perception Survey in Sierra Leone which showed that 88% of respondents saw lack of finance as a barrier to accessing care, the second most significant barrier was distance and a lack of transport however this was listed by only 6% as a barrier.

Table 1: Reason for not accessing assistance from health facility



Source: National Service Delivery Perception Survey, 2008

The PM compares selected healthcare worker salaries in Sierra Leone with those in neighbouring countries (Liberia and Gambia) which illustrates that healthcare workers were paid significantly less but this comparison only includes 3 staff groups (doctor, midwife and state enrolled community nurse) therefore a comparison across all staff groups is not presented. It also compares 2010 pay scales in Sierra Leone with those in Liberia in 2007 and Gambia in 2006.

It has not been possible during the evaluation to identify the process undertaken by GoSL to determine what the level of salary uplift for different grades of staff should be because the stakeholders interviewed were not involved in that decision-making process, nor is this process described in the documentation provided during the evaluation. The evaluation team were able to obtain copies of the current pay scales for healthcare workers, and also copies of the current pay scales for other GoSL workers which enabled some comparison of the differences between the health sector and other GoSL staff, but they were unable to obtain a copy of the healthcare worker pay scale prior to the implementation of FHCI and the subsequent salary uplift. The implementation of the new salary scales is discussed further in this report in response to Question K.

2.1.3 Gaps or weaknesses in the evidence base

c) Were there significant gaps and/or weaknesses in the evidence base used to justify the decision to contribute to increases in healthcare worker salaries?

Prior to DFID SL intervention there was little or no reliable evidence on the healthcare worker salary situation however the GoSL payroll was agreed to be grossly inaccurate. Staff numbers, job designations and workstations were known to be inaccurate and there were many ‘ghost-workers’ on the payroll. Heavy reliance on ‘volunteers’ to provide health services was known to distort the picture of the actual numbers of healthcare workers and other personnel working in the health sector. Even basic staffing establishment and staff in-post data was known to be inaccurate. These challenges were addressed by the initial payroll cleansing component that preceded the AMS implementation.

Similarly there was no robust evidence of the extent of formal and informal fee charging in the absence of any agreed statement of fees and any form of record-keeping on income and expenditure at either facility or central levels. The evidence available was primarily stakeholders’ knowledge of existing custom and practice and the general acknowledgement that fee charging was a significant barrier for access to health care.

In addition, data on service provision was not particularly robust as facilities were being built without Government approval – by both the private sector and local benefactors – and some Government facilities were providing only minimal services because of a lack of staff, equipment and functional infrastructure. The MoHS now has a better understanding of service provision within the Government sector but the non-public health sector (private and faith based organisations) remains outside of MoHS regulation. This is important to note because it means that the MoHS does not know the extent to which the FHCI is being implemented within these sectors.

The TORs for the upcoming four year impact evaluation acknowledge that the evidence base in Sierra Leone is comparatively weak as a result of the destruction and disruption caused to the management and delivery of basic services across the board, including health care provision. The FHCI is recognised as an innovative response to the crisis of unacceptably high maternal and child mortality rates and “therefore does not have a strong local evidence base”[5] .The TORs also state that whilst a number of countries have introduced schemes to reduce the impact of cost on health seeking behaviours, particularly by vulnerable groups and including exemption schemes, the removal of fees and revised pricing systems, there appears to be limited evidence of the impact of such schemes on health outcomes and mortality. In particular there is little evidence to underpin the theory that increasing healthcare worker salaries will eliminate improper charging and increase staff attendance. This emphasises the importance of robust evaluation of the impact of this specific initiative in order to better evaluate the appropriateness of this response, identify lessons learned, and contribute to the national and international evidence base.

[5] DFID SL Operational Plan 2011

2.1.4 GF decision-making around support to healthcare workers salaries

e) How has the Global Fund approached its decisions to pay healthcare worker salaries in line with DFID, and what lessons can be learned from their decision making?

Both DFID SL and GF share joint payroll and attendance monitoring performance indicators developed in collaboration with the MoHS. This is entirely consistent with the principles of donor harmonisation and alignment described in the Health Compact. The GF uses the Human Resources for Health Support Unit (HRH SU) and the payroll and attendance monitoring systems to implement its remote allowance initiative. This collaboration ensures consistency and complementarity, and avoids duplication. Streamlining both processes through the same systems minimises the risk of contamination of the existing payroll.

Whilst there is a strong degree of high-level commitment to joint working between DFID SL and GF, the 2012 DFID Annual Review states that 'there is variable GF engagement and understanding at working level of the objectives of the programme and the details of the reforms being implemented'. This is primarily evidenced by inconsistent GF engagement with the Project Steering Committee (PSC), however the Annual Review report notes, that this has improved more recently. As noted elsewhere in this evaluation report the GF is a somewhat passive member of the PSC[6]. The joint DFID SL and GF decision to withhold funding and enforce the conditionality of the funding agreement for the salary uplift was critical in ensuring the active participation of the MoFED in performance management of the initiative.

The evaluation team were unable to identify any specific lessons that could be learned from GF decision-making, either from the document review of from stakeholder interviews conducted during the evaluation period.

2.1.5 DFID and GF processes for transferring funds to Government

f) How has DFID handled the process by which funds have been transferred to government, in partnership with the Global Fund, through established mechanisms like the Healthcare Worker Steering Committee?

A Memorandum of Understanding between GoSL (acting through MoFED), the National AIDS Secretariat (NAS) (the Principal Recipient of the GF Round 9 Grant), and DFID (acting through DFID SL) was signed in February 2011. This Memorandum contains the responsibilities of the parties involved in meeting pay for healthcare workers in Sierra Leone. It is enacted through PSC.

DFID SL and NAS have worked together to ensure their procedures are aligned for disbursing funds for health worker salaries. This was also the case for the Global Fund (GF) who had to align their advance tranches to the attainment of the PSC benchmark. DFID SL and the GF approve the release of salary tranches based on satisfactory attainment of the benchmarks agreed upon by the PSC. Payments of monthly salaries are through the normal Government payroll and audit is undertaken to ensure the accuracy of salaries paid by the Accountant General.

Approval for release of funds is usually granted or rejected during the PSC meetings. This was the case at the July 2012 PSC meeting attended by the evaluation team when DFID SL and GF granted approval based on satisfactory performance supported by a report on Group 1 and 2 indicators. In November 2011, 75% salary

[6] Direct observation of the evaluation team and analysis of the PSC Meeting minutes.

disbursement for November-December 2011 was approved and 25% withheld due to late submission of attendance data. After approval at the PSC stage, a formal request for funds must be made by the MoFED and this involves communication from MoHS to MoFED before the request for funds is made.

At the July 2012 PSC meeting which was attended by the evaluation team, concerns were raised by DFID SL that the release of their funds to the GoSL Consolidated Fund were being delayed due to bureaucracy within GoSL institutions. Action was agreed to immediately address the concerns raised.

2.1.6 MoHS leadership and ownership

g) To what degree does senior management within the Ministry of Health provide leadership, and feel ownership, of the changes in healthcare worker salaries?

MoHS leadership is evidenced primarily through its participation in the PSC and its management of the payroll and AMS. Stakeholders interviewed report a high level of ownership and a commitment to maintaining the integrity of the payroll. The Directorate of HRH has recently bolstered the HRH SU by deploying one extra staff member to support the Head of the Unit. While this is welcomed, the staffing of HRH SU remains inadequate and heavily dependent on the inputs currently provided by CGA.

The HRH SU conducts attendance verification spot checks as needed and conducts targeted *District Support Assessments and Operational Capacity Checks* to analyse the ability of each district to manage the AMS, related HR issues and M&E activities. The qualitative observations and quantitative data assessments through this tool allows for headquarters to give attention to districts and hospitals in specific areas where necessary and to better understand data validity from multiple measures. In 2012, it was planned that supportive supervision would be undertaken in 10% of all facilities. The evaluation team noted that in July 2012, 24 visits were planned but 39 visits were actually undertaken. The effectiveness of these visits could not be established since some were taking place at the same time as the evaluation. The findings from supervision visits are shared with the facilities and the DHMTs. While the target is to cover 10% of all facilities in 2012, the proposal from the PSC is to set the target at 25%.

2.1.7 Involvement and ownership of other implementing ministries

h) To what degree do other implementing Ministries---for example the Ministry of Finance, Human Resources Management Office, and Accountant General's Department---feel ownership of, and contribute towards, the healthcare worker salary uplift?

Somewhat surprisingly, given the usual preference of similar institutions to maintain uniformity of pay and conditions across the whole of the public service, HRMO claimed to be a leading player in planning and implementing the health technical workers revised pay scales. There appear to have been two factors contributing to this positive attitude: i) a general recognition that everyone in the Sierra Leone public service was miserably paid and therefore deserved a salary increase, so taking advantage of the willingness of external partners to support higher salaries was an opportunistic way of benefiting at least some of those for whom they felt responsible; and ii) the fact that there were precedents for paying specific groups more in recognition of labour market shortages, specifically in donor funded project management teams.

HRMO was intimately involved in the re-grading exercise which preceded introduction of the new salary scales and in the subsequent recruitment drives in February/March 2010 and March/April 2012. HRMO also helped to define the AMS and its attendant sanctions. Now that the system has stabilized, it is the HRMO which instructs the AGD to make changes to the payroll, acting on information supplied by HRH SU. HRMO has been a consistent presence in the Payroll Steering Group, and in the person of its Director a very engaged member.

MoFED has been something of a silent partner, but its role has been critical, first in agreeing to the new salary scales (the Ministry has assumed the major part of this cost from the outset, and will bear the cost from 2015 onwards, and secondly, in agreeing to the additional recruitment to MoHS. There are in effect two controls on the recruitment process. HRMO determines the establishment which reflects an ideal pattern of staffing of government health services; there were 21,653 posts approved as of June 2011. MoFED determines the number of funded posts; this is the effective ceiling on the employment capacity of MoHS. The number of filled posts at June 2011 was only 8,576, or less than half the establishment. The Budget Director in MoFED recognises that they have held down employment in the health sector in recent years while priority has been given to the security services, but anticipates that a greater expansion will be permitted to the health and education sectors in future years.

MoFED engagement as a member of the Payroll Steering Committee has been sporadic with some delay in requesting payment of the two monthly tranche from the partners, until the meeting at which DFID SL and GF announced that they were willing to release only 25% of the tranche because of delays in reporting attendance monitoring. Since then the Ministry has taken a greater interest in attending all PSC meetings.

The AGD is the branch of MoFED which composes the payroll and instructs the transfer of funds to the individual accounts of public servants held in commercial banks. Its role in relation to the salary uplift is that of an implementing agency, acting on instructions received from HMRO. There are indications that it has not always acted promptly on change instructions. In the long run, this is not highly significant, as the corrections eventually made are retrospective, applying additions or deductions to total pay as appropriate. It may however be argued that it would be preferable for sanctions to be implemented promptly to deter future infractions. AGD has not always attended the Payroll Steering Group, and has not been very active on the occasions when it was represented, though in fairness the main issues raised have not impinged heavily on its role.

It seems fair to conclude that the other Ministries have fully supported the concept of the salary uplift and have played their respective roles in its implementation with no signs of reluctance.

2.1.8 DFID technical advice to Government

i) How has DFID managed and used its high level advice – both through official technical support packages and informal policy advice – to key government decision makers in order to deliver the policy?

DFID SL is supporting policy development with the provision of two technical advisors who are embedded in the MoHS providing support to the Director of HRH and the Director of RCH. This is a mechanism for providing high level policy advice that is responsive to changing contexts and emerging needs within the health sector, as well as building MoHS capacity for policy development and implementation.

Specific areas where policy inputs are currently being provided include: development of the Scheme of Service; HRH policy documentation; development of the HRH Strategic Plan; and the development of the Basic Package for Essential Health Services. However, whilst these are priority areas for HRH and MoHS policy development, progress to date has been constrained by the weak capacity of the MoHS to meet its workload demands with its current staffing levels[7], especially the high demands on the workload of the Director of HRH and as a result these components of work are yet to be concluded.

In order to improve aid effectiveness, reduce the high level of fragmentation in the health sector and work in a more coordinated, effective and resource-efficient manner Sierra Leone signed up to the International Health Partnership Plus (IHP+) global agreement in May 2010. A Health Compact was developed for Sierra Leone in December 2011, signed by the development partners including DFID SL, which provides the governance framework for the implementation of the National Health Sector Strategic Plan (NHSSP) 2010-2015. A Joint Programme of Work and Funding (JPWF) was subsequently developed to operationalise the NHSSP in January 2012. The 3-year costed JPWF provides a comprehensive framework for aligning interventions to sector priorities, as well as planning, monitoring and budgeting processes.

DFID SL inputs to supporting FHCI are provided within the framework of the Health Compact. The Memorandum of Understanding between DFID SL, MoHS and MoFED describes the conditionality attached to funding of the FHCI. DFID SL has a critical role in providing high level policy advice to MoHS through its role in the Health Sector Coordinating Committee which it co-chairs with UNICEF. DFID SLs decision to refocus its programme following the launch of FHCI resulted in the embedding of Technical Advisors into the MoHS to work alongside MoHS counterparts as one mechanism for strengthening MoHS capacity to implement the FHCI.

In addition DFID SL has been able to provide informal policy advice through components of work commissioned through Options at the request of the MoHS, for example: 'Restructuring the MoHS: Options for Change' (September 2010) 'Restructuring the MoHS; Rapid Diagnosis' (December 2010); 'RCH Programme Sustainability Review' (December 2011) and 'A Rapid Assessment of Staff Performance Management Systems' (April 2012). Through its support for such activities, while not directly providing policy advice, DFID SL has been able to strengthen MoHS capacity for informed decision making

2.2 Impact evaluation

2.2.1 Salary uplift to healthcare workers

2.2.1.1 Impact of salaries uplift on health outcomes for target groups

j) What has been the overall impact on health outcomes for target groups of increased salaries being paid to healthcare workers in the context of free healthcare?

The impact on health outcomes, in terms of infant, child and maternal mortality, cannot be measured at the present time. There has been no population based sample survey of mortality rates since April 2010 when FHCI was implemented. Prior to that time, information is available from the Multiple Indicator Cluster Survey round 4 (MICS4), conducted in 2010 but with estimated results centred on 2008,

[7] Summary report on Joint Health Sector Review Field Visits, June 2011

MICS3 with data from 2002, and the Sierra Leone DHS 2008. The reported trend in mortality can be seen in the series below:

Table 2: Historic health impact indicators

	MICS3 2002	MICS4 2008	DHS 2008
Infant Mortality Rate	158	128	89
Under five mortality rate	267	217	140
Maternal mortality ratio	857		

The report on MICS4 is silent on the large discrepancy between its findings and those of DHS, which are usually taken as the “gold standard” for estimates of mortality.

There are comments in the 2010 Performance Report which have a bearing on these figures. In relation to Infant Mortality Rates, the report observes that there was a reduction in the case fatality rate for child admissions to hospitals, attributed to earlier admission induced by access to free services. In relation to the under-five mortality rate, it states that it is thought the 2008 DHS undercounted child deaths and the most recent WHO/UNICEF estimate was 192/1,000. In relation to Maternal Mortality Rates, it notes that the rate for hospital deliveries in 2010 was equivalent to 951/100,000. This figure is difficult to interpret as an indicator of population wide mortality, because while hospitals are better equipped to deal with complicated deliveries, if the referral system is working well they have a disproportionate share of those complications.

While it is currently not possible to measure impact at the Goal level, it is feasible to measure attainment at the Purpose level. An analysis of trends in utilisation should therefore provide some evidence of the results of the intervention to raise health worker salary levels. The critical question is whether the increase in service uptake which immediately followed the introduction of free Maternal and Child Health (MCH) services has been sustained. It is known that there was a severe disruption to the drug supply in 2011 which could account for the decline in patient volumes in that year compared with 2010. The picture at both national and local level seems very mixed. Evidence on this point is summarised below, and developed further in Annex 10.

Comparisons at the national level are handicapped by the fact that the 2011 Performance Report is in a different format from that of 2010, and it is at present only in a draft form. As a consequence, it is difficult to present data in a consistent time series. The following table is based on data contained in these two reports:-

Table 3: Utilisation data at the national level 2009 - 2011

	2009	2010	2011
Under 5 outpatient consultations (000s)		2,450	1,450 (est.)
Fully immunized)%)	64%	75%	70%
Pregnant women attending at least 3 ANC (000s)	149	168	173
At least 2 doses TT (%)	53%	64%	59%
At least 2 doses IPT (%)	58%	99%	75%
Hospital delivery (number)		13,750	15,103
Delivery by skilled birth attendant (number)		121,821	129,821
Caesarean section (number)			2,350

There are problems of attribution at two levels. The extent to which changes in health status can be attributed to health service utilisation is unknown, but it is plausible that in a context such as Sierra Leone the wider application of low cost and effective health technologies (immunisation, prevention and treatment of malaria, oral rehydration salts for diarrhoea, facility deliveries) could have a significant impact on child and maternal survival rates. To borrow a phrase and a concept, Sierra Leone is not yet "practising medicine on the flat of the curve".

The second attribution issue is to estimate the extent to which greater utilisation has been driven by the uplift in health worker salaries, when this is only one of a series of interventions made by GoSL and its development partners. The point of greatest vulnerability in most schemes to introduce free health services is the difficulty in ensuring an adequate supply of drugs. Both the volume of drug supplies and the systems of drug management and distribution have improved markedly, although many problems remain. It is clear also that there has been a major investment in buildings and equipment in recent years. Since all of these reforms have been national in scope, there are no natural experiments that would permit unpicking the relative contribution of each intervention.

2.2.1.2 Impact of DFID contribution to salaries uplift on health outcomes

k) To what extent is DFID's support to healthcare workers salary uplift contribute to the overall impact on health outcomes?

The salary uplift undertaken in Sierra Leone was a large multiple of the preceding salary bill, in contrast to the situation in other countries in which external partners' supplemented salaries in order to overcome problems of unattractive salaries (as in Malawi and Zimbabwe for example). On average, health worker salaries in Sierra Leone rose by a factor of two to three times their original level, but the new salary scales were decompressed by giving only small increases to the lower grades and much larger increases to the most senior grades. For example, specialist doctors on Grade 12 had their salaries almost quadrupled, whereas salaries for Grade 1 only increased by 34%. At the same time, more than half of technical health workers were advanced in grade. This combination of salary increases by grade and grade

advancement produced steep increases in take home pay for some health workers, and a near tripling of the total government health wage bill.

A preliminary issue is the actual cost of the salary uplift. This is not quite a simple before and after question, because the salary bill did not remain constant after 2010. Figures supplied by MoFED show that the original budget provision for salaries in 2010 was Le 24.4 billion, and the actual expenditure was Le 63.4 billion. In 2011, Le 82.3 billion was budgeted, and actual expenditure came in at Le 76.4 billion. The jump from the actual 63.4 billion in 2010 to the actual 76.4 billion in 2011 was greater than could be explained by the increase in the number of months for which higher salaries were paid (in 2010 the new salary scales were effective from March, so the new rates were paid for only 10 months). How much of the further increase in 2011 was attributable to the additional recruitment and how much to other factors, including a possible redefinition of those entitled to salary uplift, is unclear from the accounts given to the evaluation team. It is known that the original intention was to restrict the salary uplift to “frontline” health workers, a concept that would have excluded laboratory technicians (despite the fact that they were in a position to charge patients for laboratory tests). The line of demarcation eventually adopted was whether a staff member was liable to transfer from the MoHS, in which case they would not be eligible for the increases. What is not known is when this change in defining eligibility was implemented.

DFID contribution to the salary uplift

Although the composition of the elements accounting for the increase in the salary bill is unclear, the total sums budgeted and actually spent are clear from the expenditure data produced by MoFED. The contributions of both DFID SL and the GF were paid into the Consolidated Fund account of GoSL with the Central Bank, and were thereafter indistinguishable from other revenue receipts. The difference between the total salary bill and the external contributions represents the GoSL contribution to the cost of health workers salaries.

There are two problems in establishing the relative contributions of the co-funders of the health salary bill. The first is that the timing of the payments of DFID SL and GF are not precisely known. The schedule of payments from DFID SL is expressed in UK financial years; these have been converted to calendar years reflecting the Sierra Leone financial year. The schedule of payments from GF is expressed in quarters from the date of inception (September 2010). Unfortunately, these straddle the calendar and financial year; it has been assumed that payments for the quarter December 2010 to February 2011 were actually made in 2011.

The second issue is that the external contributions are expressed in pounds sterling and US dollars. These have been converted to Leones using mid-year interbank exchange rates taken from oanda.com but since there have been currency fluctuations within years GoSL might not have received exactly the amounts expressed in Leones. The calculation then proceeds as set out in table 4 below (all figures in Leones billions):

Table 4: Respective contributions of GOSL and external partners to the cost of salaries

	2010	2011	2012	3 year totals
Total health salaries (1)	63,397	76,376	74,783(2)	214,556
DFID contribution (Leones)	16,071	15,500	15,140	46,711
GF contribution (Leones)	3.342	18,311	21,461	43,114
GOSL contribution (3)	43,984	42,565	38,182	124,731
Memorandum items:				
DFID contribution GBP	2.75m	2.25m	2.25m	7.25m
GF contribution USD	0.865	4.256m	4.976m	10.099
GBP conversion rates	5844	6889	6729	
USD conversion rates	3860	4302	4312	

Notes. (1) Figures are actual expenditure for 2010 and 2011, budgeted amount for 2012. (2) It seems likely that the budget estimate will be substantially exceeded in 2012, as first quarter actual expenditure came in at Le 19,887B. (3) This is not reported, but calculated as a residual in the table.

The bottom line is that DFID will have contributed an average of 21.8% to the total cost of health worker salaries over the first three years of the scheme, the GF will have contributed almost exactly 20%, and GoSL will have contributed 58.1% of the total. The DFID contribution was particularly important in the first year, when it accounted for over a quarter of the total cost. It has since declined both in absolute terms and as a share of the total, and is due to decline further before ending in 2014. From the outset, GoSL has been the major supporter of the salary uplift, and its share will increase until it reaches 100% (assuming no new donor commitments).

2.2.1.3 Impact on charging of user fees

I) To what degree has the charging of key user groups stopped and/or been reduced as a result of the higher salaries for healthcare workers?

There are three main sources of information on the extent of fee charging of MCH patients. The first is a national survey carried out by HFAC in 2011, described in their second report on “Independent Monitoring of the Free Healthcare Initiative” released in July 2011[8]. This report concluded that 20.4% respondents had been asked to pay for a service that should have been free.

The second source of information is provided by the exit survey carried out by the evaluation team during the week 02-07 July 2012. Findings of the exit survey are attached at Annex 11. Although this was not a rigorous large scale study, the findings showed that among the random sample of 218 patients interviewed, approximately 20% of those who should have received free services were in fact charged by the

[8] The study does not report how respondents were selected, what was the time frame for incidents of charging, and other methodological issues.

facility they attended. The geographic distribution also corresponded to that found in the HFAC study, with Western Areas and Port Loko district being the locations in which the highest incidence of fee charging was reported.

The third source of information is the discussions which the evaluation team had with the DHMTs, Medical Superintendents, health workers and others, notably the staff and volunteers of HFAC. Here a clear line of division emerged. Independent informants had numerous accounts of improper charging, and HFAC members explained how they had drawn these incidents to the attention of the relevant District Medical Officer (DMO) or Medical Superintendent, with variable outcomes. The healthcare workers were adamant that illegal charging was not occurring. Pressed on this point by questions which sought to investigate special circumstances, health workers consistently denied that there were any deviations from the free healthcare policy. They could give no accounts of actions taken to pursue offenders. In one district, it was acknowledged that allegations of improper charging had been made in two cases, both of which on investigation proved to be legitimate charges.

The discrepancy between the assertions of healthcare workers and the evidence collected from other sources during the evaluation period suggests a toleration of infractions by healthcare workers.

The ability to charge fees to MCH patients is fostered by the very opaque arrangements surrounding fee charging for other categories. The current system for supplying cost recovery drugs is in disarray, with some facilities denying that they have any, others acknowledging that they have some but being totally vague about issues of pricing and re-supply. In no case did the evaluation team encounter complete books of accounts recording income and expenditure from fees or drug sales. Not a single informant acknowledged that they had the authority to set fees, referring variously to others (MoHS, DHMT or Village Development Committees) as the bodies that determined fee levels. In practice, it seemed most likely that fees were set by the in-charge of each facility, and in hospitals, by the in-charge of each department, who were not accountable to any external authority.

One other frequently encountered situation was where the health staff informed the patient that an item (drugs, blood) or service (ambulance) was not available, leaving the patient to purchase on the open market. In this way, the policy was technically observed, in that the facility had not collected money from the patient, but the patient had been denied access to what should have been provided. It is evident that some of these incidents of non-availability are genuine, because the whole system is inadequately resourced; others however may have been deliberately manufactured in order to induce patients to pay. In the exit survey, the main reason given for payment for drugs is that the patient was told that there was no free drug available.

Based on the interviews undertaken during the field visits the evaluation team were unable to establish whether or not there was any link between the increase in healthcare worker salaries and reduced fee charging. Interviewee perception is that health workers deserved higher salaries because they were miserably paid in the past with no recognition of the expectation that they would be required to give up that part of their former income which was generated from other sources, including the charging of fees for target groups. To the extent that they are now compliant with the expectations on attendance, it appears that it is the penalties that might be imposed for unauthorised absence and not the inducement of higher salaries that motivates the behaviour change. This is not to say that raising salaries was not critical to the success of the FHCI---it was clearly a pre-requisite, as acknowledged elsewhere in

this report, but it was not sufficient to completely eliminate improper charging of target groups.

For that to occur there would need to be a change in institutional culture throughout the government health system, which might be brought about by a systematic set of policies driven from the top. These policies should include: an insistence on proper accounting for all fee collection and expenditures from fee income; total transparency in the display of fees applicable at each facility, and a clear cut statement of entitlements of MCH patients; an avenue of complaint for aggrieved patients; a system of sanctions for infractions parallel to the existing sanctions for unauthorised absence; more adequate provision and supervision of the supply of drugs, safe blood and ambulance services, and greater engagement with system managers at district level to secure their allegiance to the policy of free health services for target groups. If even a small fraction of the effort that has been put into control of unauthorised absence had been applied to improper fee charging, it is likely that it would now be a relative rarity.

A HFAC national manager informed the evaluation team of a complicating factor; that there is at present no clear framework defining improper behaviour by health workers in relation to improper charging nor graduated sanctions of the type applied to unauthorised absence. Even in cases of theft, where both the police and the Anti-Corruption Commission became involved, health workers were rarely held accountable, because cases became delayed in the courts and the evidence muddled.

2.2.1.4 Impact of other factors affecting formal & informal remuneration

m) What other factors are determining the formal and informal remuneration of healthcare workers on the ground and what impact does this have on the goals of the healthcare salary uplift policy?

Remote area allowance

When the decision was taken to raise health worker salaries, the increases were related to grades and the presumed need to improve incentives nationwide. In 2011, the GF responded to a request from MoHS to consider providing additional funds to enable payment of a remote area allowance to compensate employees for the many disadvantages of living outside the main urban centres and thereby make postings to such locations more acceptable. The scheme eventually adopted provides for additions to basic salaries, graduated as follows:

10% addition	Western Rural Areas or within 10km of regional or district HQ (RHQ and DHQ)
15% addition	>10km from RHQ or DHQ
25% addition	>10km from RHQ or DHQ and no car access during the rains
40% addition	>10km from RHQ or DHQ and no motorcycle access during the rains

GF provided an initial US$240,000 in September 2011 and further amounts of $238,000 in March 2011 and $251,000 in May 2012. In principle, the allowances are paid quarterly in arrears. The funds pass from the National AIDS Secretariat as Principal Recipient of GF support, to the Department for Planning and Information (DPI) in the MoHS as Sub-recipient, and then to DHMTs which in turn credit the bank accounts of eligible health workers. The sums applied to date suggest an average benefit of around 5% of basic salaries, but because of the way the allowance is structured, large numbers of health workers in Freetown are excluded from the benefit, and the highest benefit accrues to a presumably quite small minority of health workers on relatively low basic salaries serving in the most arduous parts of

the country. While there may be a case for minor amendments to the criteria and the scales, the basic concept seems admirable and perfectly aligned with the objective of increasing access to health services for the poorest.

Performance based funding

The Performance Based Funding (PBF) supported by the World Bank and administered by DPI seeks to reward those facilities which achieve above target levels of performance in the provision of high priority services. These include treatment of children suffering from malaria and deliveries conducted with the partograph. In principle, the payment is made to the facility rather than the staff, but the rules provide that 60% may be used as incentives to health workers. In practice, this percentage may be exceeded as only small expenditures for non-salary items were found. But as with accounting for other expenditures, no comprehensive statements of income and expenditure from this source were found during the field visits. It is clear that, in this instance, PBF produced additional income for health workers since it was paid in addition to basic salary and was not an alternative mode of payment, as has been applied in some situations. However, it is not clear that the scheme is wholly beneficial.

A systematic review of the global literature[9] concluded that the case for PBF was not proven. Moreover, it specifically mentioned that some unintended adverse effects might be induced. The first of these is the risk of concentration on activities for which additional income can be earned, to the detriment of equally important activities for which no additional payment is made. Almost the counterpart of that is the risk of concentration on those patients who are easy to treat (cherry-picking or cream-skimming). A third risk is that health workers may soon learn to manipulate the system by misreporting activities and outcomes. A fourth risk is that inequity in rewards may be intensified. There is some suggestion from the interviewees that the latter two could potentially be occurring in Sierra Leone. One worker, who had apparently gained little from the first round of PBF, reported much larger numbers for the second round. When questioned, she replied "*now we know how to fill in the forms*". It is not totally clear whether she intended the face value of these words and she is now more familiar with the requirements for completing the forms, or if she was indicating that she now knew how to manipulate the system to produce higher rewards. Another MCH Aide complained that she would never qualify for additional payments in respect of deliveries because she had no partograph.

Daily subsistence allowance

A third source of supplementary income from official sources is the daily subsistence allowance (DSA) which health workers receive for attendance at workshops. This was not closely investigated, but anecdotal reports suggested that the DSA could produce a large increment to normal monthly income, and that many workshops were unnecessarily extended to maximise the entitlement to DSA of those attending. Given the low levels of basic education prevalent in Sierra Leone, and the deficiencies in professional education which are now coming to light, in-service training is a legitimate strategy to improve health worker skills. What cannot be avoided is that some individuals see training events as a means of enhancing income, rather than acquiring desirable skills.

Other sources of income

There is one potential source of formal income additional to basic salaries which the evaluation team did not pursue. This is allowances paid with salary through ADG. It appeared from a perusal of one payroll printout that there are columns prior to those

[9] Witter S, Fretheim A, Kessy F, Lindahl A, Paying for performance to improve the delivery of health interventions in low and middle income countries, Cochrane Library, Issue 2

in which deductions are listed, but neither the categories nor the magnitude of such allowances were investigated.

Turning to the informal modes of supplementing the government salary, one that is reported anecdotally to be highly prevalent is **moonlighting**, or taking a second job. This can take one of two forms: either employment on a full or part time basis with another employer, or self-employment as a private practitioner. One interviewee claimed that nurses from a district hospital also worked for an international NGO, and falsified the attendance register in order to do so. This could not be corroborated by the evaluation team but if true it raises serious concerns. Apart from the loss of time from official duties entailed by this practice, the long hours involved must also imply some loss of alertness while on duty, so patients attending government facilities are disadvantaged twice over. The ills of dual practice are very well known; suffice to say that if official practice is poorly regulated, it is predictable that unofficial practice will depart even further from ethical practice and good clinical standards.

Based on the interviews undertaken during the evaluation it appears that the **sale of drugs** by health workers is commonplace. Exit interviews show that this sometimes includes drugs that should be provided free of charge under FHC, not just cost-recovery drugs and other drugs not included in the essential drug list. Whilst the sale of effective and appropriate drugs prescribed by a trained health worker may be preferable to self-diagnosis and purchase of dubious drugs from a pedlar, the practice is open to abuse and would not be necessary if the system of cost recovery drugs functioned properly and the supply of free drugs for MCH patients were adequate. As it is, deficiencies in these systems provide cover for practices which enrich health workers at the expense of some of their most vulnerable patients, including the sale of free MCH drugs.

A slightly different issue is raised by the **charging fees for services**, be it a consultation, a laboratory test or a surgical procedure. Stakeholders interviewed at MoH, district and facility level report that there is no approved schedule for the sale of services that states which patients should pay for which services, nor what those charges should be. Charges for services are arbitrary, non-regulated and determined - at best - at facility level, but possibly even determined at individual healthcare worker level. Given the limitations of public finance, and the high cost of producing some of these services, in a mixed financing system it may well be considered perfectly appropriate that patients (other than those in the target groups) should make a direct contribution to the cost in the form of an official fee. The potential for abuse arises when the level of fees is not transparent, is determined by the provider and the proceeds are not brought to account but disappear into the pocket of the provider. This behaviour amounts to theft since all the inputs, including the provider's own time, have already been purchased from the public purse. Moreover, the prevalence of unregulated fee charging increases the temptation to charge those who should be exempt. By its nature, the extent of sale of services for private reward is difficult to ascertain, but it is probable that it produces a considerable supplement to the incomes of those in the higher reaches of the publicly funded health system.

The theft of **drugs and equipment for sale to third parties and/or for use in private practice**, was believed to be highly prevalent before FHCI and the salary uplift, and was to a degree condoned because of perceived low salaries. There is an impression that the incidence of outright theft has since reduced, notwithstanding the large number of cases still open and the difficulty in gaining convictions in those cases that do reach the courts. Clearly theft is entirely detrimental to the goals of the FHCI.

2.2.2 Payroll improvement

2.2.2.1 Status of the payroll

n) To what degree has the payroll been cleansed and improved as a result of DFID's technical support to the Ministry of Health

Progress made against the project implementation roadmap has been satisfactory. The payroll data from the Accountant Generals Department (AGD) shows that as at 30 June 2012, the payroll had 8,647 heath workers excluding volunteers. From 2010 the following objectives have been achieved:

- Building on Government payroll cleaning exercise of 2009;
- Development of the excel based Attendance Monitoring System (2010-2012);
- Implementation of the system in all the Districts and HQs (2010-2011);
- Training of officers (on-going).

Since the payroll was cleaned in March 2010, the process of 'salary stoppage-hold' and 'salary release-unhold' involves several offices. The DMO requests the changes through the Attendance Monitoring System (AMS) district tool and the HRH SU compiles all the cases, checks records, forwards to the AGD department and finally forwards to the HRMO to effect the change.

System controls are not currently built-in to the attendance system. These controls include who can make changes in the records and also basic audit trail functions. At present, data from the DMO is checked by the HRH SU every month and any changes in payroll figures and numbers are easily detected. This close scrutiny and management of the payroll is currently mitigating against the re-introduction of payroll irregularities and, whilst this level of scrutiny is maintained, it is unlikely that 'ghost workers' can be reintroduced to the payroll. Available data suggests there are currently no irregularities in the payroll.

There are indicators that demonstrate integrity of the payroll and these have to be met before release of funds to MoHS. These indicators are:

i. % of staff with job designation listed in the payroll
ii. % of staff with defined workstation that are on the payroll (MoHS data compared with payroll);
iii. % of staff with job description that matches their pay grade; and
iv. % of staff reported to be on study leave with authorization from HRMO.

Three of these indicators must be met before the release of 50% of funds. MoHS has regularly met all the indicators and release of funds has been interrupted only once. During the evaluation, all the indicators were met as at July 2012. These indicators are attached in Annex 12.

Attendance monitoring system

The AMS relies on facilities management for tracking and reporting of all MoHS staff attendance. The MoHS consolidates attendance and staff data from electronic attendance tools submitted by all districts and hospitals each month. M&E officers, data entry clerks or other appointed officials at the District Office and hospitals compile all monthly attendance summary forms and enter the data into the provided electronic tool. After data is entered into the tool, senior management reviews the data for accuracy and completion. Data files are sent to the HRH SU by the 15th-20th of each month. This data is used to update the central database and implement the changes and updates requested. The system updates human resources data and also informs and updates staff salary payments.

In systems development, a systematic approach from design to implementation is followed to ensure full system institutionalization with an emphasis on development structure, planning and control. At the planning stage, infrastructure requirements, human capital needs, systems support and interface with other systems are usually addressed. While the AMS could have identified some of these issues as possible risks to full institutionalization of the system when it was designed, it was not necessary to focus on such issues at that time since the basic ICT infrastructure was non-existent. The system was supply driven to address the issue of staff attendance and was developed primarily as a monitoring system that would keep the payroll clean and monitor staff attendance. For that reason, the user needs assessment approach used in systems development was not necessary. The selection of Excel package for the system tool was, at the time, ideal to meet the overall objective of the payroll management and attendance monitoring.

The Excel system is easy to use since the software is commonly available and popular among public officers. However, the software has its limitation as data is stored in rows and columns and as the number of rows increases, data management could be an impediment. For that reason if the numbers of MoHS personnel increases the system will face processing challenges. The strength of this system is the simplicity and ease of use and training on Excel is also possible in a short period. The disadvantage is its limited capacity for expansion into a system which goes beyond simply monitoring. For this reason the MoHS may need to implement other parallel systems to collect subsets of data that is already managed through the AMS.

Effectiveness of staff registers

All heath facilities, hospitals and MoHS headquarters complete manual registers, which are the source of data for the AMS. This intervention has created a sound basis for sanctions for non-attendance but also has introduced a culture of work which has contributed to compliance attendance. Officers record their names in the register and sign attendance daily. This data is delivered to the DMO around the 5th of every month. Application of the register system has demonstrated a 96.6% compliance rate, as shown by figures reported in July 2012.

Support for payroll management and AMS

Support for the system is provided by contracted technical team that supports three officers in the HRH SU. A member of the technical team is involved in upgrading and modifying the system when changes are requested. The software development includes macros which require advanced skills in Excel. For this reason officers in the Support Unit are not able to make any changes to the source code which is also locked to ensure definitions and formulae in columns and rows are protected. Governance structures are shown in Annex 13.

Role of ICT Directorate

The Ministry has just created a new Directorate of Information Communication and Technology (ICT) whose mandate includes support and coordination of infrastructure and systems within the MoHS. It will take almost a year before the directorate develops a strategy and has a footprint in on-going systems support activities in the departments.

Key Challenges for the implementation of payroll management and AMS

A number of challenges were identified during the evaluation, specifically:

I. ***Capacity of the HRH SU.*** The HRH SU needs to be developed to the point where it is able to support the payroll and attendance monitoring systems without external support since the current TA support will not be provided long term. The current support team includes the supervisor –public health sister,

data entry clerk and second grade clerk. In addition, there is an assistant secretary attached to the team. The team is suited for the roles they are currently undertaking but still remain reliant on CGA for 'trouble-shooting', and especially for providing IT support. In terms of future developments, the team would find it very difficult to modify or develop the current system without external assistance.

II. ***Inadequate infrastructure***. Limited infrastructure within the Ministry and the Districts is an impediment. The system is run on two desktop computers and data archive is done using Drop Box. The external backup tape was faulty at the time of the evaluation.

III. ***Security and access control.*** The payroll system contains confidential information, including details on salaries, and as such the possibility of fraud and/or misuse should be an area of concern. Ideally controls against these risks should be built into the system but this is an area where Excel has limitations. Close monitoring by HRH SU currently mitigates against these risks but the system itself could be strengthened with the inclusion of some further controls, particularly: the encryption of information to prevent disclosure of AMS information to un-authorized persons; user authentication to ensure that only authorised users gain access to the AMS application, and the establishment of an audit trail.

IV. ***Limitations of the systems.*** There is need for an integrated payroll and personnel system in Government, but the current payroll system and AMS does not provide MoHS with a HRMIS and this is an area which is now being developed with World Health Organization (WHO) support. It is important that this initiative build on gains made by the AMS which now provides clean payroll data which could be used to populate tables being developed under the HRMIS initiative. The development of an interface between HRMIS and AMS is included in the CGA/GF ToRs however delays in WHO advancing this work has delayed this specific CGA activity.

Making better use of data already available on the current system would eliminate duplication in data collection since data sources and management for both systems is through the HRH SU.

A further limitation is the fact that the payroll system is not currently able to produce consolidated data on staff numbers by job title and grade at facility, district and central levels. This is important for effective HRH management and workforce planning.

Human Resources Information System

During this evaluation it was noted, as mentioned above, that the MoHS is implementing a Human Resource Information System (HRIS) funded through the WHO. Under Phase I this system has been already been piloted in the Western Region, collecting new HR information including data already in the current system. Phase II of the HRIS has included setting up a server, a LAN and a data centre in the HR directorate.

These infrastructure developments could be used for both AMS and HRIS since these initiatives are in the same department. HRH SU is also tasked to manage the HRIS. This could lead to multiple data entry and over working the AMS personnel. This will negatively impact on the management of AMS. During implementation of this system, no reference was made to the AMS. This has led to collection of new information including information AMS has already cleaned for the last three years.

2.2.2.2 Estimated savings accruing to Government

o) What are the estimated savings accruing to government as a result of the elimination of ghost workers and/or more effective use of human resources through the public health system as a result of DFID intervention?

Monetary savings

The monetary savings from the first round of pay freezes aimed at eliminating ghost workers are calculated at US$ 408,200 over the 27 month period March 2010 to May 2012, according to the MoHS Pay and Output Monitoring Project Progress Report 2 dated June 2012. It is interesting to note that of the 1,626 names initially removed from the payroll, all but 297 have since been reinstated, as they either returned to work, or were found to have been on study leave, or other satisfactory explanations emerged. A further 127 had their pay frozen as of March 2011 on the grounds that they had no known workstation; of these, only 31 had returned to the payroll as of May 2012, generating a further $211,600 in monetary savings. The same source notes that in the 16 months since the introduction of the Conduct and Sanctions Framework, 534 individuals have been sanctioned for non-attendance, with a consequent saving of $79,200. The total estimated saving to date is $699,000 - $408,200 from the payroll cleaning exercise of March 2010 and $290,800 since introduction of Conduct and Sanction Framework.

While it is clearly desirable to avoid the waste implicit in paying staff for work they have not done, and the monetary savings are not insignificant, the larger benefit of the payroll reforms is the motivation they have provided for the publicly financed workforce to be present and on time. Compared to the totally unregulated situation which existed previously, with an unknown level of absence from duty, the present situation is that the health workforce is predictably present on duty and understands that unauthorized absence will no longer be tolerated.

It is interesting to note that Sierra Leone did not have the problem of ghost workers in the form in which they exist in some countries, where names on the payroll are wholly fictitious and salaries are collected by politically powerful but corrupt individuals. The larger problem in Sierra Leone appears to have been that people who were once genuinely entitled to be on the payroll and to receive salaries had discovered that they did not need to be present or to work in order to collect a salary. They could afford to take second jobs and enjoy a second income, secure in the knowledge that there would be no repercussions. As the payroll freeze was instituted, the great majority decided that they would be better off returning to work with the MoHS, particularly in the light of the much higher salaries that then became payable.

Management of human resources

The system supports effective management of HR resources since the number of staff, their designation and station is accurately recorded in the AMS which is then translated to accurate MoHS payroll. In addition, the number of volunteers working in each facility, but not in the payroll, is known and if there is a discrepancy, the Ministry can make a quick intervention should it choose to do so.

It was noted during this evaluation, that although reporting using the attendance tool is done by monitoring and evaluation officers who are in the districts, the DHMT had problems providing the evaluation team with staff data. None of the DHMTs visited during the survey could generate staff numbers or readily provide information on their staff by grade and number in-post and yet the attendance tool contains staff data which is updated every month. It is recommended that training in the districts focus

on ensuring that AMS is not just providing data to the centre but that it is used in the districts for HR management purposes.

Improvement in the payroll

There has been tremendous improvement in the quality of MoHS payroll data and its management. The data is accurate and reliable (numbers and payroll amounts) and shared by MoHS, HRMO and AGD and therefore supports improved workforce planning. The system has made coordination easier since information sharing is immediate. Data is maintained monthly removing risks of re-introducing ghosts-workers. As reported in July 2012, 99.7% of staffs in the payroll have an identified job designation.

2.2.2.3 Effectiveness of systems for payroll management

p) How effective are current systems in place to monitor, record and amend the payroll in light of joiners/leavers/transfers etc.?

Management of amendments

The system has provision for the following amendments: promotion, salary upgrade, arrears or re-instatement, deletion from the payroll, change of station, change of designation, salary, and name change. Currently an improved system is being tested by the HRH SU which involves printing the amendments requested, checking in the registry for the relevant documents, making approval or rejects and forwarding the print out with the requested changes to the AGD payroll unit in the Ministry. The department forwards the requested amendments and supporting documents to HRMO

While the new system simplified the processing of amendments at MoHS, it remains to be seen how these amendment requests will be managed by the HRMO. HRMO uses an Integrated Financial Management System (IFMIS) to post the changes, and whether or not the system will accommodate the requested changes is yet to be determined. In May 2012, 84 requests for job designation changes were made by the districts - 50 of these cases were rejected at MoHS level and 34 cases were forwarded to HRMO. In July 2012, none of the cases forwarded had been acted upon by the HRMO and the AGD.

2.2.2.4 Access to the payroll by new joiners

Access to the payroll for new joiners has been slow. After interview of each new employee the HRMO issues an appointment letter but before the employee can be included in the payroll a PIN code is issued and their photograph and fingerprint is verified. However HRMO will do not add the new employee to the payroll until NASSIT numbers and bank details are provided. Of the 1,474 new employees recruited in the recruitment campaign in March/April 2012, only 8% (124) had been added to the MoHS payroll of June 2012. The issuing of NASSIT numbers and opening of bank accounts has delayed access to the payroll, an issue discussed during the July 2012 PSC meeting.

2.2.2.5 District level support for the payroll system

q) To what degree do responsible staffs in the districts (DHMT and local council staff) understand and support the objectives of the payroll improvement system?

DHMT's support

DHMTs and Hospital Management Committees contribute to monitoring the attendance programme through Supportive Supervision and Verification exercises at their facilities. Districts are responsible for attendance verification during these supervisory visits. Verifications of hospital departments and district-wide facilities are conducted on a quarterly basis. HRH SU has trained and worked with DHMT including development of tools for the verification exercise. The monitoring and

supervision findings are reviewed by HRH SU staff during their support supervision visits in the Districts. While DHMT confirmed carrying out verification exercises but key issues identified during these exercises are not recorded or processed in a way that would inform or improve facility management.

DHMTs convene meetings on the 5th of every month to discuss the registers submission from the facilities. The facility in-charge confirmed that indeed they travel every month to the Districts to submit the registers. However DHMT endorsement of the payroll improvement policy is itself selective. There is total approval of the notion of enhanced salaries for health workers. The uplift was thought to be a long delayed recognition of their worth to society. There is general approval of the additional recruitment to the health workforce, which has put many who were formerly working as “volunteers” on the payroll. There is complete understanding of the procedures involved in attendance monitoring, and universal acceptance that the reporting requirements are not onerous. There is a grudging acceptance of the sanctions policy and it was universally acknowledged to be the threat of penalties that had brought about a huge reduction in absenteeism. There was some questioning of why a health worker should lose a whole month’s pay for six days of absence, but the progressive nature of the sanctions was seen as an appropriate managerial response to unacceptable behaviour.

DHMT members make no association between higher salaries and refraining from imposing fees on target groups. They understand perfectly well that there are no charges that may legitimately be made if the patient is a pregnant or lactating woman, or a child under five. They do however deny that any such charges do occur, despite cases being brought to their attention by HFAC and others. In effect, they are operating a “don’t ask, don’t tell” policy.

District Council support

The position of district councillors and their senior staff is different, in that they feel largely detached from payroll issues and indeed anything to do with the discipline of health workers as all such matters are handled by the DHMT and central authorities in Freetown.

They were quite insistent that health workers should be their direct employees so that they could exercise what they thought were their rightful responsibilities. Understandably they were somewhat insensitive to the drawbacks of local government employment of professional staff in a skilled labour shortage environment. They have no sectoral interest in differential higher salaries for health workers. The aspect in which they are most interested is general oversight of health workers conduct through Village Development Committees, and specifically the management of drug distribution.

2.2.2.6 Effectiveness of central MOHS systems and new HSC

r) How effective are central Ministry of Health systems for managing the healthcare payroll and what are the potential gains from establishing a new Healthcare Services Commission?

While efforts by MoHS to ensure only bona fide health workers are in the payroll, supporting processes should not be addressed in isolation but be guided by government policy. The processes for: declaring vacant posts; adding staff to the payroll; deployment; payment of salaries; updating the payroll and continuously monitoring the wage-bill; attendance; training; disseminating circulars: and the method for effecting changes in the payroll should be addressed through a broader business process review approach which is embedded in Government policy While some changes of policy may be necessary, and HRMO can provide guidance on this

issue, the result would lead to improved businesses processes and inform the development of the HRIS and the future human capital management system for Government. Furthermore, a number of processes can be defined as 'historic administration' in that they have been followed by MoHS for a long time but may not have much current relevance.

Given the importance of the new Health Services Commission, and its potential impact on the context in which the programme is being implemented, it has been given significant consideration during the evaluation. A brief report which addresses Part 2 of this specific question, as well as providing supplementary information, is attached at Annex 14.

2.2.2.7 Lessons from comparable countries

s) What lessons can be learned from comparable countries that have implemented similar systems?

Governments in Africa continue to face challenges managing payroll and controlling the public service establishment. This is attributed to:

- Weaknesses in internal controls, resulting in high expenditures on personnel emoluments and discrepancies between the establishments register and the payroll; and
- Absence of timely, accurate and comprehensive information on both payroll and establishments, resulting in overruns in the personnel emoluments budget and payroll fraud

The size of Sierra Leone Public Service (approximately 30,000 excluding Special Forces) is relatively small compared with for example, Zambia, Uganda, Tanzania, and Malawi, each with over 500,000 employees. The weaknesses are common across many countries where reform programmes have been introduced. This sample of countries initiatives were not driven by the same staff attendance problems identified in Sierra Leone, since in these countries staff absconding from duty meet high penalties including dismissal, as the code of conduct and rules have evolved over time and are very effective.

Payroll cleaning

Although many initiatives have been undertaken to address the weaknesses and improve timely provision of payroll and human resource management information, payroll cleaning has always been identified as the starting point and a preparatory activity for introduction of Integrated Payroll and Personnel Systems (IPPS). While consultants have been used to support payroll cleaning and implementation of these systems, inputs from Government technical staff have been instrumental in making these systems work.

Currently the Government of Swaziland, with a size of public service similar to Sierra Leone, is developing a framework for payroll cleaning and this is a useful example of IPPS development. The activity will be undertaken as a three month project with results used for cleaning the payroll *and* updating the HR data. During the exercise, an assessment of the HRMIS and payroll system processes will be carried out with the aim of strengthening the controls in *both* systems.

Public sector reform programmes

These initiatives have been funded through Public Sector Reform Programmes (PSRP) and have enjoyed sustained political support and commitment. Uganda started with Poverty Reduction Support Credit from 2001 and continues to benefit from World Bank funding and from this support in 2005/06 started with payroll cleaning and is currently implementing IPPS using 'Systems, Application, Products in

data processing' (SAP) [10]. Tanzania is implementing the Second Phase of their five year PSRP and has been implementing their Human Capital Management Information system for over 10 years. Here the system was centralised although since 2011, efforts to decentralize the system have been in progress. Systems implementation initiatives are supported by international consultancy firms working with contracted local personnel over periods of more than five years. SAP implementation in public service is faced with many challenges which include complexity of the public service processes, poor infrastructure and limited skills in managing SAP.

HR and payroll systems

The HR systems have always been owned by the Ministry of Public Service equivalent to HRMO in Sierra Leone. Countries mentioned are implementing SAP which are made up of modules that generally address: (i) Organizational Management (development and maintenance of organizational structures); (ii) Personnel Cost Planning and Control (which monitors expenditure against approved Personal Emolument budgets); (iii) Personnel Administration and Time Management (maintenance of employee data to ensure compliance with the terms and conditions of service including attendance management and leave management); (iv) Payroll Management (calculating the employee's earnings in a given period of time taking into account the available budget and the terms and conditions of services); (v) Authorizations (addresses the issues of system security); and (vi)Training (manages training requests).

The payroll system is always under the Ministry of Finance. In an effort to reform financial management, PSRP have been supporting implementation of the IFMIS. In many countries, the HR system provides payroll data to the IFMIS through an interface.

Costs and funding

Implementation and management of these systems is a costly exercise that cannot be solely financed by Government generated resources, particularly for Sierra Leone. The costs range from US$ 3 million for capital expenditure and US$ 10 million for operational costs. Most countries undertaking activities to improve payroll management and HR systems have benefitted from development partner funding through their PSRP.

2.2.3 Attendance monitoring

2.2.3.1 Effectiveness of the AMS In incentivising healthcare workers

How effective is the current attendance monitoring system in incentivising healthcare workers to report for work?

A functional attendance monitoring system is now in place. The system is simple, well understood and is easily implemented at facility and district levels. The sanctions for non-attendance are also well-understood at all levels and the HRH SU reports submitted to the PSC confirm that sanctions are being imposed and salaries withheld for non-attendance in line with the Conduct and Sanctions Framework. Some districts do however report high numbers of staff with unauthorised absence. The MoHS attendance summary for March 2012 shows that some districts and hospitals continue to have high reported rates of both authorised and unauthorised leave, with some Districts reporting 10% of staff as unauthorised absence.

[10] During the week of July16-20, 2012 top management from HRMO visited Uganda on a benchmark study tour funded by World Bank as SL prepares to introduce a government wide Human Capital Management Information System

Attendance monitoring at facility level remains challenging – the remote locations and difficulty in ensuring adequate monitoring and supervision of facilities with only one or two staff provides opportunity for misreporting of attendance. It is not possible to ascertain the extent to which any transgressions occur, for example: if staff sign for their attendance each day or whether this is done retrospectively at the end of each month; whether a staff member signs in and then leaves the workplace early to undertake work elsewhere; whether a staff member signs in for an absent co-worker etc.

2.2.3.2 Effectiveness of the AMS In sanctioning non-attendance

u) How effective is the current attendance monitoring system in sanctioning non-attending healthcare worker staff, and what impact is this having on behaviour on the ground?

DHMTs describe how they undertake monitoring and supportive supervision, including monitoring of staff attendance, but realistically this can only be undertaken infrequently and spot-checks are unlikely to happen in the more remote facilities. district council officers report that they undertake some monitoring but again the frequency is questionable.

The decision to involve civil society in monitoring health sector performance is a very positive way forward however there is a heavy reliance on community and civil society organisation engagement in monitoring attendance and fee-charging. HFAC through its Memorandum of Understanding with the Anti-Corruption Commission has a particular role but has limited capacity and resources to fulfil its mandate fully, particularly in reporting, which means that the evidence emerging for this specific aspect of performance monitoring is not as robust as it could be. HFAC uses the Monitoring Toolkit developed with DFID SL support to undertake its monitoring activities and the efforts to streamline and strengthen the different aspects of HFAC monitoring is valuable however HFAC has recently had to revise its monitoring schedule in order to better manage its resources and workload. Each monitor is now responsible for 6 facilities and monitors 2 facilities per month; therefore each facility is only monitored once each quarter.

It is reported that some communities take action when staff absence is noted, for example reporting it directly to the DMO, the Ward Councillors or ‘phone-in’ shows on local radio etc. but the isolation of some staff from direct management and supervision does provide ample opportunity for staff absence without the threat of sanctions. That said, it is likely that sanctions and withholding of salary for non-attendance is the critical driver for improved attendance. There is no perception that the requirement for improved attendance is in anyway associated with the salary uplift.

There is little evidence that any sanctions are being imposed in regard to improper charging and the evidence from all stakeholders interviewed during the evaluation suggests that there is no correlation between salary uplift and the elimination of improper charging.

2.2.3.3 Sustainability of the current system

v) How sustainable is the current system given the likely trajectory of DFID support in the medium-term, and what systems could be put in place to improve the chances of sustainability?

The system was developed as a stop gap measure to support health workers salaries enhancement and provide attendance data to ensure only bona fide heath workers were paid and were attending their workstations. The effectiveness of this system is not in question but the sustainability of the system beyond December 2012

when the contract for CGA is of some concern. The risk is associated with lack of technical personnel in the HRH SU to fully support the system. The personnel in the unit that play a key role in managing the system will need support from an IT technical expert in the absence of future TA. The skills needed includes ability to undertake system modification and adding into the system important suggestions that districts may make during support and supervision missions.

To ensure sustainability of this system, MoHS should ensure that the TA team works with technical MoHS IT staff in specific functional areas to facilitate the transfer of skills and knowledge. This evaluation provides three options for consideration in the medium term listed in the Table 5 below. Annex 15 lists risks associated with sustainability of the systems.

Table 5: Options for medium term support for payroll and AMS

	Option for future support	Advantage	Disadvantage
1.	Hire an experienced local technical staff with skills in programming and excellent user of excel for a limited period of two years	Quick transfer of skills from CGA to the staff.	Local talent may not be available in the next one month but are available in other West Africa countries.
2.	Appoint a GoSL programmer	Public officer and part of the establishment.	Risk of losing the officer to the private sector.
3.	Outsource systems support to a local firm	The company will take full responsibility and will not depend on one staff member	This alternative could be expensive and skills transfer to GoSL maybe not happen.

Sustainability of the salary uplift

Barring subsequent renewals, DFID support to health worker salaries is due to end in 2015 and GF support later this year (2012). DFID support was originally designed to be front loaded, relieving GoSL of part of the initial shock of meeting higher health worker salaries, and allowing a progressive shift to GoSL taking up a larger share of the cost involved. The subsequent addition of GF support at a higher annual rate, but for a shorter period and without any tapering, has produced a different time profile of obligations for GoSL.

GoSL contributions actually fall over the period 2010 to 2012, both in absolute terms and as a percentage of the total cost of health workers' salaries, but are then set to rise abruptly in 2013 and 2014.

The data in the following table are drawn from the response to Question (k) of the TORs, and a tabulation "Analysis of Government health expenditure 2008-2012" produced by the Budget Bureau of MoFED. This tabulation also has projected values up to 2014.

Table 6: Future cost of healthcare worker salaries to GoSL

Figures in billions of Leones	2009	2010	2011	2012	2013	2014
Total cost of health salaries	19.6	63.4	76.4	74.8	83.8	84.5
Net cost of health salaries to GOSL	19.6	44.0	42.6	38.2	72.0	77.8
Total GOSL salaries	401.5	535.6	681.3	798.3	907.4	916.1
Total GOSL expenditure	1003.7	1482.4	1714.7	1867.8	1920.7	2114.4
Row 1 as % of row 3	4.9	11.8	11.2	9.4	9.2	9.2
Row 2 as % of row 3	4.9	8.2	6.2	4.8	7.9	8.5
Row 2 as % of row 4	2.0	3.0	2.5	2.0	3.7	3.7

Note: Figures 2009 -2011 are actual expenditures, 2012 -2014 are projections.

This tabulation shows that GoSL has hitherto been protected from the full cost of the salary uplift to a greater degree than was originally planned, but it will face almost the full cost in 2013 and 2014, and the full cost from 2015 onwards. Its ability to absorb the cost increase is indicated by the last two rows of the table, which compare the net cost of health salaries to the total GoSL salary bill and to total GoSL expenditure respectively. The figures suggest that the jump in the cost to GoSL of health salaries in 2013 and 2014 will be absorbed comfortably within the pattern of total growth in government expenditure.

2.2.3.4 Improvement in attendance and health outcomes

w) To what degree is any improvement in attendance impacting on healthcare outcomes for targeted populations?

There are many factors known to be critical in determining healthcare outcomes. Not only have staff to be present but they must have adequate knowledge and skills and have the relevant equipment, environment etc. all of which are known to be deficient in the health sector in Sierra Leone.

Those facilities that have received support from external development partners have clearly seen an improvement in the availability and quality of infrastructure, equipment and consumables but those facilities that have not received this level of support continue to have inadequate resources to deliver the basic package of essential health services. DHMTs and facility staff interviewed consistently reported that they had no functioning fridge, blood pressure monitoring equipment, inadequate drug supplies and incomplete delivery sets etc. as well as buildings that are in poor structural condition.

MoHS recruitment efforts have successfully increased the number of healthcare workers on the payroll but the data provided during the evaluation indicates that many of the new recruits were already working within the health facilities as volunteers, suggesting that although the number of staff on the payroll has increased the actual number of healthcare workers providing care has not increased significantly. In addition many of the staff added to the payroll (up to 50% in some Districts) comprised lower grade support staff (cleaners, labourers, security etc) rather than clinical staff providing direct patient care. This is especially true of the March 2012 recruitment campaign because most of the clinical staff who had been

working as volunteers had already been put on the payroll following the first recruitment campaign in 2010.

Despite MoHS recruitment efforts the District level stakeholders interviewed indicate that there is still inadequate staffing in most health facilities. At hospital level the gaps are mainly at senior level, especially doctors and midwives, and at PHU level many facilities still only have 1 or 2 technical healthcare workers at MCH Aide level and above, with the remainder of workers comprising support staff and volunteers. Clearly the provision of 24 hour services, 7 days a week, in this circumstance is difficult even where staff attendance has improved.

Staff training is also critical for ensuring healthcare outcomes and many healthcare workers have already accessed training provided by the development and implementing partners. An analysis of the impact of the training on healthcare outcomes is beyond the scope of this evaluation but the evaluation team emphasises the importance of ensuring that training is actually resulting in better quality service provision. It is essential that staff participation in training events is well coordinated so that absence from their workstation is minimised but clearly this needs to be balanced with the need to improve skills – both of which are critical for improved healthcare outcomes. The MoHS is already aware of the need to develop a training plan which addresses identified training needs whilst limiting staff absence from the work place.

Increases in service utilisation as a result of FHCI are discussed elsewhere in this report and are therefore not repeated here. However, in regard to the link between improved staff attendance and increased service utilisation, the evaluation team conclude that it is highly likely that there will have been some positive impact if staff are now available at their workstations to provide services when patients attend where they were not before, but it is not possible to provide evidence at this point in time to demonstrate that this is in fact the case.

Although AMS has resulted in improved staff attendance at their work station, the evaluation team conclude that it is still very difficult to determine whether or not improved staff attendance is resulting in better healthcare outcomes. The hypothesis of the theory of change that improved staff attendance will subsequently improve healthcare outcomes is perfectly reasonable, but at this point in time there is limited data available to demonstrate that this correlation exists.

2.2.3.5 Effectiveness of PSC in overseeing the AMS

x) How effective has the Payroll Steering Committee been in overseeing the attendance monitoring system?

As mentioned previously, the release of DFID contribution for healthcare worker salaries is conditional on MoHS performance on payroll management and attendance monitoring. GF also uses the same mechanism for the release of its contribution. It is clear that GoSL fully understands the conditionality attached to both DFID SL and GF support for healthcare worker salaries; that robust performance management is critical; and that continuing performance improvement is expected.

The PSC meets every two months and is chaired by the Director of HRH. It comprises MoHS staffs including the HRH SU, HRMO, MoFED, DFID SL, GF, MoHS TA and CGA representatives and is responsible for setting and monitoring performance targets. The main agenda for the PSC meetings is to review progress on indicators and targets which determine whether funds are released. In previous meetings MoHS performance was reported to the PSC by CGA on behalf of the HRH SU but at the most recent meeting (July 2012), the results were reported by HRH SU

for the first time in line with the decision to increasingly transfer responsibilities from TA to the MoHS as part of the exit phase of the current component of CGA support.

The DFID/GF joint decision to impose sanction by withholding 25% of funding in November 2011 when performance targets were not met served to emphasis this fact and suggests that the PSC is effective in enforcing prompt reporting on indicators and targets.

2.2.3.6 Effectiveness of the PSC results framework

y) How effectively has the results framework for the Payroll Steering Committee both captured key outputs the system intends to produce, and supports incentivised action from government to improve its performance?

Three groups (with a total of eleven indicators) were introduced in 2010 and are used to monitor progress:

- Group 1: 3 of 4 must be met to release 50% funds;
- Group 2: 3 or more must be met for 50 % funds;
- Group 3: No disbursement implication.

The indicators demonstrate integrity of the payroll and that AMS is working. The targets and actuals for January 2012 and the performance in July 2012 are included in Annex 12. This evaluation confirms that reporting from the districts was excellent between April and June 2012 with only one district submitting a late return.

Overall, the targets are met however; there have been discussions in the PSC about the relationship between inputs and outputs. The concern has been whether success in health worker attendance has correlation with the outputs of the health facility i.e. number of patients seen and if there is a relationship between facilities with better attendance and those who deliver more outputs.

The targets are set annually but are reviewed at each meeting and are uplifted as and when the context and improved performance allows. The decision-making for target amendments is captured in the summary notes produced at each meeting which is important for monitoring and evaluation purposes. However, although all PSC members contribute to the discussion and are involved in decision-making about target setting, it would appear from the analysis of the PSC meeting minutes and the evaluation teams observation at the July 2012 PSC meeting that DFID SL remains the driver for improved performance, with both the MoHS and to some extent the GF taking a more passive role. Although it needs to be a gradual process, the GoSL stakeholders involved need to adopt a more proactive role so that, by the end of development partner inputs, the MoHS is driving performance management.

2.3 Monitoring and evaluation

The PM describes the M&E arrangements for the programme. The planned 'impact' evaluation at the end of Year 1 did not take place but the programme was subject to DFID monitoring in both 2011 and 2012 in line with DFID's M&E framework.

The programme is no longer providing support to HFAC. Although HFAC continue to access support for operating costs from UNICEF[11] and UNFPA their capacity for data analysis and reporting remains limited, and this is an important issue given that 3 of the 6 indicators at Purpose level stated in the programme LFM are dependent on HFAC reporting. Unless HFAC are provided with further support to build their capacity for reporting, DFID SL should consider whether or not they will have access

[11] UNICEF funds HFAC from DFID funds through the Medicines and Medical Supplies for the Free Health Care Initiative Project. This support ends in December 2012

to sufficient data to enable them to fully determine whether Purpose level indicators 4, 5 & 6 can be evaluated at the end of the programme period in the absence of quality reports from HFAC. If not the current LFM may need to be further amended.

3 Conclusions

The impact on health outcomes, if by this is meant changes in infant, child and maternal mortality, cannot be measured at the present time as there has been no population based sample survey of mortality rates since April 2010 when FHCI was implemented. In addition it is difficult to attribute the extent to which greater utilisation has been driven by the uplift in health worker salaries, when this is only one of a series of interventions made by GoSL and its development partners. What can be said with confidence is that the salary uplift was critical to the success of the FHCI thus far. Prior to March 2010, the GoSL health workforce was functioning at a very low level of commitment, with high absenteeism and the constant distraction of the search for additional income. At that time a strike of health workers was threatened in protest at their low wages. The announcement of greatly enhanced salary scales had an immediate effect in attracting new recruits and changing the incentive structure for existing employees. DFID SLs decision to support the salary uplift was also catalytic in the sense that it leveraged much larger contributions from GoSL and GF.

A critical success is that the majority of patients in the target groups for FHCI now benefit from access to free healthcare – this is a major achievement in the relatively short timescale since the initiative was introduced. However, improper charging of some patients entitled to free health care continues and, although the scale of it cannot at this point be fully determined, the exit survey undertaken as part of this evaluation provides a ‘snap-shot’ suggesting that as many as 20% of FHCI beneficiaries attending GoSL facilities are required to make some level of payment. There is no evidence that those staff members known to be participating in improper charging are ever sanctioned. This situation is exacerbated by the total lack of regulation for formal user fees which facilitates and enables improper charging. Similarly the difficulties in ensuring adequate drug supplies at facility level - of free FHCI drugs but also cost recover drugs – is another enabling factor which is used as justification for improper charging. There is no correlation between reduced fee charging and higher salaries and no such association exists in the minds of healthcare workers or their district level managers.

The PSC has played an important role in implanting the salary uplift and the engagement of all senior level stakeholders via their membership of the Committee has helped to foster ownership and commitment. It also provides a useful mechanism for strengthening GoSL capacity for performance management and cross-Ministry collaboration.

Although the evaluation has identified a number of challenges that remain in relation to successful implementation of FHCI, it is evident that much progress has been made in a relatively short time frame. There is widespread confidence about the accuracy of payroll data. With DFID SL support the healthcare worker payroll has been cleaned and an effective payroll management system has been put in place. Close monitoring and strong management arrangements put in place under the direction of the PSC, have resulted in greater confidence that the payroll has been rid of ghost workers, the number of staff on the payroll reporting to their workstations has increased and staff are being paid at the contracted grade. The timeliness of payroll amendments has improved significantly – although pressures remain when large numbers of amendments are required, for example following the recent

recruitment drive – but this is a major improvement compared to previous when staff were working for months, or even years, as volunteers without being formally paid through the GoSL payroll.

Interrogation of the data provided by GoSL indicates that the salary uplift is financially sustainable in line with the agreed GoSL/DFID SL/GF funding arrangement. The payroll management and attendance monitoring systems are also sustainable in principle but there are some concerns about the capacity of the HRH SU to maintain the system if there are any technical issues or if the units' workload increases such as is likely when it becomes more involved with the development of the new HRMIS. DFID SLs decision to refocus its programme of support in response to the launch of FHCI and in particular its support for the salary uplift is obviously appreciated by GoSL and is considered as a critical factor enabling the implementation of FHCI, however challenges remain.

While it is currently not possible to measure impact on health outcomes in the absence of any population based sample survey of mortality rates since April 2010 when FHCI was implemented, it is feasible to measure attainment at the programme purpose level, which was stated to be "to increase the uptake of health care by the most vulnerable". Data at national level from the HMIS indicates an initial steep increase after the announcement of the FHCI in April 2010 in utilisation of maternal and child health services, with a slight decline in the last quarter of 2010. In 2011 there was a considerable fall in under-five attendances, though not to the level of 2009, while maternity related services showed a slight upwards trend. The setback in 2011 is thought to be related to disruptions in drug supply, since corrected, but data for the first 2 months of 2012 does not suggest reversion to the high levels of utilisation found in 2010.

The programme emphasis on strengthening management of the payroll and attendance monitoring, and thereby ensuring that DFID SL resources are used appropriately, has produced very positive results. Additional emphasis now needs to be put on addressing other critical factors for the FHCI, such as the removal of user fees and tackling improper charging in order to increase service utilisation, which are both fundamental to DFID's theory of change.

The scope of the TORs for this evaluation focuses primarily on payroll management and attendance monitoring. The 4-year impact evaluation, commissioned by DFID SL and commencing in the coming months, has a wider scope which considers the impact of interventions on the elimination of user fees and improper charging, increased service utilisation and the quality of service provision. The draft ToRs for the impact evaluation do address these areas.

4 Recommendations

1. The MoHS should address the issue of user fees for non-target group patients. This should include establishing the arrangements for setting, implementing and monitoring fees.
2. There is a need to establish a mechanism for investigating allegations of improper charging, which is needed to strengthen the implementation of this specific component of the Conduct and Sanctions Framework.
3. The payroll system should be modified so that it is able to produce consolidated data on staff numbers by job title and grade at facility, district and central levels. This is important for effective HRH management and workforce planning.
4. The PSC should monitor service utilisation rates more closely. Better interrogation of this data will enable more robust conclusions to be drawn as to whether or not there is any correlation between attendance rates and service utilisation. This need only involve a small number of indicators and the disaggregated data is already available from the DPI. Undertaking this on a quarterly basis, for example, will allow more effective monitoring than reliance on annual MoHS performance data.
5. The new MoHS ICT department should be co-opted to the PSC meetings to provide technical input for IT support for the payroll and attendance monitoring systems. Their input will strengthen coordination of system re-development and address infrastructure issues including training of support personnel.
6. Since both AMS and HRIS are GoSL initiatives, there is need to effectively coordinate IT infrastructure and human capital to ensure cost efficiency and effectiveness and eliminate duplication of effort and wastage of resources.
7. The MoHS, with support from HRMO, should consider the value of undertaking a business process reengineering review focusing on key processes that will inform and provide input to the development of HRIS.
8. The LFM needs to be amended to make the link between Outputs and Purpose more explicit. This should be undertaken as an activity during the forthcoming impact evaluation given that it is highly likely that further amendments will be needed at this time.
9. SL should consider the likelihood of having sufficient data to evaluate Purpose level indicators 4, 5 & 6 at the end of the programme period in the absence of quality reports from HFAC. If not the current LFM may need to be amended.

Annexes

Annex 1 Terms of Reference

Background

1. DFID Sierra Leone has been a major supporter of the Government of Sierra Leone's policies to improve healthcare outcomes for poor Sierra Leoneans. Rapidly improving healthcare outcomes has been a priority given Sierra Leone's very high maternal and child mortality rates and uncertain progress towards relevant MDGs.
2. The Government of Sierra Leone's 'Free Healthcare Initiative' (*Annex A*) – launched in April 2010 – represented a major step forward in increasing access to key healthcare interventions for mothers and young children. Public service surveys had indicated that the most significant barrier to accessing healthcare was cost of services. At the same time, comparative research indicated that healthcare workers in Sierra Leone were significantly underpaid relative to their peers in comparable countries. Removing user fees for priority groups – pregnant women, lactating mothers, and children under five – while increasing the salaries of healthcare workers represented the government's key response to the issue of access.
3. To support the government, DFID SL provided policy advice through technical assistance to implementation, but also significant financial support in the form of drug purchases to meet anticipated increased demand, and contributions towards increased healthcare worker salaries up to an acceptable level and reduce the incentive for healthcare workers to continue to charge for services.
4. DFID has budgeted £10.3m to support higher salaries for healthcare workers over a five year period (August 2010 – February 2015). The programme has four outputs which will:
    - sustain the removal of user fees through a regularly paid salary uplift
    - keep the whole health payroll clean and ensure it is managed well by Government
    - generate reliable and accurate information and data enabling Government to monitor staff attendance and manage personnel deployment
    - support the implementation and where necessary enforcement of the no user fee policy
5. This support is front loaded, with the assumption that government will progressively increase its share of the increased cost. The financial aid to Government through this programme is subject to certain conditions between DFID, the Ministry of Health and Sanitation (MoHS) and the Ministry of Finance and Economic Development - MOFED, specifically the maintenance of the integrity of the payroll and appropriate performance against the agreed set of indicators and benchmarks jointly agreed between DFID and MOFED, the Ministry of Health and Sanitation - MoHS and the Human Resources Management Office - HRMO). The Global Fund have also joined DFID in supporting government in meeting the cost of higher salaries for healthcare workers subject to performance against the same indicators and benchmarks.
6. Alongside the financial support DFID has made to meet the *cost* of a better paid healthcare workforce, DFID has also made a significant investment in improvements to the *payroll management* of the same workforce. DFID has contracted – through its technical assistance package – consultants to introduce

a number of improvements to payroll management, including a payroll cleansing exercise, establishment of an attendance monitoring system, and improved coordination between key government Ministries in managing payroll changes.

7. DFID SL now seeks independent consultancy support to evaluate the impact of its support to the healthcare worker salary programme. This evaluation will take place at roughly the midpoint of the programme and at the point where DFID is no longer the major donor contributor to increased healthcare workers' salaries.

DFID's approach to evaluation

8. DFID has recently re-energised its approach to evaluation in response to the drive to improve the organisation's use of evidence to deliver results (*Annex B*). DFID defines an evaluation in line with the OECD/DAC guidance:

   'The systematic and objective assessment of an on-going or completed project, programme or policy, its design, implementation and results in relation to specific evaluation criteria' (OECD/DAC)

9. In this instance, DFID SL seeks an evaluation that covers both 'process' and 'impact'. DFID SL wishes to know whether its 'theory of change' and intervention logic has proved correct; and to know the magnitude of the impact of its intervention.

10. In line with DFID's approach, this evaluation must be done *independently* of the existing team working on the programme. DFID seeks expert and impartial evaluation of its interventions in this area.

11. It should be noted that the increase in healthcare worker salaries was a nationwide event affecting all publicly employed healthcare workers at the same time. As a result, it is not possible to undertake sophisticated control/intervention evaluations of impact. The reviewers will need to use their expertise to determine the best approach to gathering evidence to support their evaluation conclusions.

Key questions and areas of enquiry

12. The evaluation should provide responses to the following key questions

1. Process evaluation
a. To what degree is DFID's theory of change as stated in the Programme Memorandum been proved correct?
b. To what degree was the evidence that DFID SL used to justify and determine salary increases robust and valid?
c. Were there significant gaps and/or weaknesses in the evidence base used to justify the decision to contribute to increases in healthcare worker salaries?
d. How does DFID SL's theory of change and evidence base compare to that used in other DFID country offices undertaking similar programmes?
e. How has the Global Fund approached its decisions to pay healthcare workers salaries in line with DFID, and what lessons can be learned from their decision making?
f. How has DFID handled the process by which funds have been transferred to government, in partnership with the Global Fund, through established mechanisms like the Healthcare Worker Steering Committee?

g. To what degree does senior management within the Ministry of Health provide leadership, and feel ownership, of the changes in healthcare worker salaries?
h. To what degree do other key implementing Ministries – for example the Ministry of Finance, Human Resource Management Office, Accountant General's Department – feel ownership of, and contribute towards, the healthcare worker salary uplift?
i. How has DFID managed and used its high level advice – both through official technical support packages and informal policy advice – to key government decision makers in order to deliver the policy?
2. Impact evaluation
(a) – Salary uplift to healthcare workers
j. What has been the overall impact on health outcomes for target groups of increased salaries being paid to healthcare workers in the context of free healthcare?
k. To what extent is DFID's support to healthcare workers salary uplift contribute to the overall impact on health outcomes?
l. To what degree has charging of key user groups stopped and/or been reduced as a result of higher salaries for healthcare workers?
m. What other factors are determining the formal and informal remuneration of healthcare workers on the ground and what impact does this have on the goals of the healthcare salary uplift policy?
(b) – Payroll improvement
n. To what degree has the payroll been cleansed and improved as a result of DFID's technical support to the Ministry of Health?
o. What are the estimated savings accruing to government as a result of the elimination of ghost workers and/or more effective use of human resources through the public health system as a result of DFID intervention?
p. How effective are current systems in place to monitor, record and amend the payroll in light of joiners/leavers/transfers etc.?
q. To what degree do responsible staff in the districts (DHMT and local council staff) understand and support the objectives of the payroll improvement system?
r. How effective are central Ministry of Health systems for managing the healthcare payroll, and what are the potential gains from establishing a new Healthcare Services Commission?
s. What lessons can be learned from comparable countries that have implemented similar systems?

(c) – Attendance monitoring
t. How effective is the current attendance monitoring system in incentivising healthcare workers to report for work?
u. How effective is the current attendance monitoring system in sanctioning non-attending healthcare worker staff, and what impact is this having on behaviour on the ground?
v. How sustainable is the current system given the likely trajectory of DFID support in the medium-term, and what systems could be put in place to improve the chances of sustainability?
w. To what degree is any improvement in attendance impacting on healthcare outcomes for targeted populations?
x. How effective has the Payroll Steering Committee been in overseeing the attendance monitoring system?
y. How effectively has the results framework for the Payroll Steering Committee both captured key outputs the system intends to produce, and supports incentivised action from government to improve its performance?

Methodology and approach

13. The evaluator will be responsible for determining their approach to answering these key questions. DFID SL will not prescribe any particular approach but expects that previous experience and expertise will be deployed to develop the most efficient and effective manner to providing answers to the key evaluation questions above.

14. DFID SL will expect the evaluator to submit a description of their methodology and approach with their proposal document. The methodology and approach will be evaluated and approved by DFID and the MoHS Department of Planning and Information (DPI) who lead on monitoring and evaluation for the Ministry prior to the signing of the contract. The methodology and approach should align with the DFID framework for ethics in research and evaluation (*Annex C*)

15. The degree to which this evaluation can determine the relationship of the health workers salaries programme to the health outcomes may be limited. The final programme evaluation in 2015 will be informed by the annual DFID impact evaluation of the Free Health Care Initiative (June 2012 – May 2016) to determine the health outcomes as a result of the Initiative in the target groups of pregnant women, children under five years and lactating mothers and the impact it has had on maternal and child mortality in Sierra Leone. Specifically the FHCI impact evaluation will provide:

    - an assessment and creation of an evidence base against which it will be determined whether and how the FHCI is contributing to a decrease in maternal and child mortality;
    - an independent evaluation where lessons will be generated to improve understanding of the impact of and operational effectiveness of the FHCI;

- an improved understanding of the socio-cultural considerations that affect the uptake of health care amongst the FHCI target groups in Sierra Leone;
- improved utilisation of information and data to inform the effective management of the FHCI within the context of delivering the National Health Sector Strategic Plan.

16. The key stakeholders are directorates within the Ministry of Finance and Economic Development, the Ministry of Health and Sanitation and the Human Resources Management Office. The DPI and DFID SL will ensure that the evaluator is appraised of the full list of stakeholders prior to the inception phase.

17. DFID SL and its technical advisers in the Ministry of Health will be able to assist the evaluator in arranging introductory meetings and providing key documentation to assist in their evaluation. It is expected that the evaluator will make several trips up country to visit healthcare delivery centres on the ground.

Outputs and deliverables

18. Expected outputs from the evaluation, with associated timescale, are as follows:

Inception period – ten working days from start of contract	
Inception Report	An Inception Report of no more than ten pages clearly setting out a proposed strategy for gathering the data necessary to answer the questions listed above within the available time. This report should identify early any challenges and difficulties the evaluator anticipates in answering the evaluation questions. This report will make clear any information and/or support required from DFID SL and its technical assistance team. DFID SL will approve this inception report as the basis for continued work on this project.
Prior to departure from Sierra Leone	
Exit presentation	A presentation of no more than ten slides setting out: • Findings from the in-country research • Expected answers to key questions set out above to be fully expanded on in the final report • Gaps, omissions, data errors and/or areas where the evaluators have not fulfilled the terms of reference and reasons why.
Five working days following departure from Sierra Leone	
Draft Final Report	A draft report of no more than 30 pages (excluding annexes) with an Executive Summary of no more than 3 pages setting out clearly the findings of the evaluation in relation to the key questions set out above. DFID will read the report and respond with comments and suggested amendments where necessary within five working days of receiving the document.

Final Report and Presentation	• A final report of no more than 30 pages (excluding annexes) with an Executive Summary of no more than 3 pages setting out clearly the findings of the evaluation in relation to the key questions set out above that responds in full to all DFID SL comments and suggested amendments. • A 10 slide presentation on the evaluation DFID SL will review the evaluator's response to its comments and suggested amendments within five working days of their receipt.

19. The evaluator will work a six day week when in country and is responsible for arranging their accommodation, transport and subsistence needs. Standard DFID terms and conditions for employment of consultants on short-term contracts– including with regard to what expenses are eligible for reimbursement – will apply.

Institutional Arrangements

20. The evaluation will be managed by the DFID Sierra Leone Health Adviser who will provide technical oversight. Support for issues regarding reporting requirements will be provided by the DFID SL Millennium Development Goal Assistant Programme Manager and contractual issues will be dealt with by the DFID SL Contracts Officer.

21. To ensure the quality of report produced and government ownership, it is anticipated that the Department of Planning and Information will appoint a focal person to work closely with the evaluator.

Timeframe

22. The evaluation is scheduled to commence in March 2012.

23. The final evaluation report and presentation will be submitted to the DFID Sierra Health Adviser no later than May 11 2012. The final report will then be shared with MOHS, MOFED, HRMO and other stakeholders as appropriate. As per DFID's Transparency agenda, the final report will also be uploaded to the DFID external website.

Profile of the evaluator

24. The evaluation requires the following essential skills and expertise:

- International track record of evaluation of programmes in resource-poor settings including the health sector in Africa.
- Expertise in health systems strengthening, including sound knowledge of health sector financial management systems.
- Experience in carrying out similar evaluations is highly desirable.
- Experience and good understanding of the health sector in Sierra Leone is preferred.
- Excellent written and verbal communication skills.

Payment schedule

25. The schedule of payments for this piece of work is as follows:

Upon signing of the contract	20 per cent
Approval of the Inception Report	20 per cent
Approval and full acceptance of the Final Report	60 per cent

February 2012

DFID Sierra Leone

Annex 2 Documents reviewed

National documents

Reproductive and Child Health Strategic Plan 2008-2010, GoSL

Demographic and Health Survey 2008

Multiple Indicator Cluster Survey and Validated Tables 2010

National Health Sector Strategic Plan 2010-2015, GoSL

Health Compact, GoSL, Dec 2011

Joint Programme of Work and Funding 2012-2014, GoSL

Health Sector Performance Report 2010, GoSL, 2012

Scheme of Service 2010 (draft)

Conduct and Sanctions Framework for Implementation of FHC, GoSL, 2010

Free healthcare services for pregnant and lactating women and young children in Sierra Leone November 2009, GoSL,

Health Services Commission Act

Report of Q1 2012 Facility Improvement Team Assessment Exercise, May 2012

Summary Report on Joint Health Sector Review Field Visits, GoSL, 2011

HRH Supportive Supervision Plan Apr-Dec 2012, GoSL

ToRs for Supportive Supervision, GoSL, Feb 2012

Pay and Attendance Monitoring System: Reference Manual Jan 2012, GoSL

Payscales Health and Technical Workers and MDA Grades, October 2011, HRMO

MoHS Report of Q1 2012 Facility Improvement Team Assessment Exercise May 2012

Restructuring the MoHS: Rapid Diagnosis–A Brief Report, K Brown and R Johnson, Dec 2010

Restructuring the MoHS: Options for Change, K Brown and R Johnson, Sept 2011

Operational Guidelines for District Health Coordinating Committees, Mar 2012

Payroll Steering Committee Meeting Summary Notes

MoHS Payroll and Attendance Monitoring Progress Reports, CGA

Programme documents

Institutional and Management Capacity Assessment SL, DFID Resource Centre, Apr 2008

Reducing Maternal and Child Mortality in Sierra Leone, Programme Memorandum, 2010

Original Programme Log Frame Matrix

Revised Programme Log Frame Matrix

Inception Report

RCH Programme Sustainability Review, A Nolan and F Humkella, Dec 2011

Technical Assistance RCH Strategic Plan ToRs, Options, amended July 2010

Proposed OD Support to RCH Directorate, June 2012

DHMT Capacity Strengthening Concept Paper, May 2012

DFID Annual Review report (2011 and 2012)

DFID Support to GoSL RCH Strategy 2008-2012, Programme Document, Jan 2009

Reproductive and Child Health Annual Review 2011

Support to RCH SL Programme Sustainability Review, A Nolan and F Yumkella, Dec 2011

Support to RCH SL: A rapid assessment of staff performance management systems, T Martineau and S Tapera, Apr 2012 (Draft)

Payroll Cleansing in Support of the Presidents Free Health Care Initiative Post Assignment Summary, Booz and Co, May 2010

Other relevant documents

Memorandum of Understanding between ACC and HFAC, Feb 2012

World Bank Aide-Memoire: Support to the MoHS, Dec 2011

Independent Monitoring of Free Healthcare, Second Report, HFAC

Report on Monitoring Activities Conducted over the First Quarter of the Free Healthcare Initiative (Draft), HFAC

HFAC Monitoring Toolkit, Feb 2012

Free Health Care Monthly Bulletin, UNICEF, May 2012

Progress report on Provision of Essential Medicines and Medical Supplies to Reduce Maternal and Child Morbidity and Mortality, UNICEF, June 2011

Annex 3 Evaluation workplan

Date	Key Milestones	Comments
W 6	Telecon DFID SL, RC, TL	
T 7		
F8		
S		
S		
M 11	Inception report	
T 12	Inception report	
W 13	Inception report	
T 14	Inception report	
F 15	Inception report	
S		
S		
M 18	Draft Inception Report to RC	2 days RC QA
T 19	Draft report to DFID SL	
W 20	Revision to report	
T 21	Revision to report	
F 22	Final report	
S		
S	Travel to SL	
M 25	SL Team meeting	09.00 Team meeting 14.00 Prince Cole Director HR MoHS 15.00 DFID Mrs Uzomaka Gilpin
T 26	SL Freetown	09.00 Permanent Secretary MoHS 10.00 Dr Kisito S. Doah, Chief Medical Officer 11.00 Mr Amara S Koroma, Director of Financial Resources, MoHS 12.00 Ms Lyn McKenzie, VSO TA to Dir Finance 14.00 Ms Judith Caine, TA CGA 16.00 Field visit planning meeting MoHS
W 27	SL Freetown	10.00 Dr Michael M Amara, Principle Health Economist, MoHS 14.00 Mr Stuart King, Team Leader Options
T 28	SL Freetown	09.30 Mrs Elizabeth Lemor, Payroll Unit MoHS 12.00 Mr Sam Tapera, TA HRH 14.00 Dr Teniin Gakurah, WHO (cancelled) 15.30 Field visit planning meeting
F 29	SL Freetown	08.30 Mr John Paul Fanning, DFID Economist 10.00 Dr Ladi Sotimehin, TA RCH 11.00 Mr Koroma, Director HRMO 12.00 Mr Matthew Dinghi, Budget Officer MOFED 13.00 Donald Conteh, Global Fund 15.00 Field visit planning meeting
S	SL Freetown	Document review, field visit logistics
S		
Mon 2 July	SL Field consultations	Northern and Southern Region field visits
T 3	SL Field consultations	Northern and Southern Region field visits Dr Teniin Gakurah, WHO Dr Augustin Kabano, UNICEF

Date	Key Milestones	Comments
W 4	SL Field consultations	Northern and Southern Region field visits
T 5	SL Field consultations	Northern and Southern Region field visits Western Area District field visits
F 6	SL Field consultations	Northern and Southern Region field visits
S	SL Field consultation	Northern and Southern Region field visits
S		
M 9	Analysis	
T 10	Analysis	16.00 Dr Magbety, DPI (cancelled)
W 11	Prep for Stakeholder meeting	14.00 Payroll Steering Committee Meeting 16.00 Dr Magbety, DPI 18.30 Mr Edward Jesu, HFAC
T 12	Debrief	12.00 DFID debrief @DFID
F 13	Debrief	10.00 Stakeholders Meeting Depart Freetown
S		
S		
M 16	Report writing	
T 17		
W 18		
T 19		
F 20		
S		
S		
M 23	1st draft Evaluation Report to RC for QA	
T 24		
W 25	Revisions	
T 26		
F 27	1st draft report to DFID	
S		
S		
M 30		DFID SL 5 days for comments as per ToRs
T 31		
W 1 August		
T 2		
F 3	DFID feedback on 1st draft	
S		
S		
M 6	Revisions	2 days for revision as per ToRs
T 7		
W 8	Final draft to RC for QA	
T 9		
F 10 August	Final draft to DFID SL	

Annex 4 DHMTs and District Councils questionnaire

Initial explanation of reason for visit, introduction of visiting team members, establish names and job titles of staff met. Assure informants that they will not be individually identified in the report except with their express permission.

Part A. Facilities in district. Draw up a matrix of facilities by type

Type of facility	Number
……………………………………………………………………………………………	
……………………………………………………………………………………………	
……………………………………………………………………………………………	
……………………………………………………………………………………………	
…………………………………………………………………………………………	

What is the total population of the district? ……………………………………………….

Are there any portions of the district which are not adequately served? Describe ………

Part B. Staffing of government services (Construct a matrix of numbers in staff categories by place of service---HQ, Hospital, PHU)

Job title	District HQ	Hospital	PHU
……..			
……..			
……..			

Part C. Utilisation of services. (Ask to see and record monthly statistics for all services since January 2010).
……

Are these figures believed to be accurate, or are there reasons to believe that there are omissions in reports received from health facilities or inaccuracies resulting in over/under reporting?

………

Do these figures suggest that the population of the district are receiving an adequate volume of health services? If not, what are the areas of deficiency? ………

Does the trend in these figures suggest a satisfactory response to the FHCI? ……………………………………………………………………………………………… ……………………………………………………………………………………………… ……………………………………………………………………………………………… ……………………………….

What problems have been encountered in introducing and operating the FHCI? ……………………………………………………………………………………………… ……………………………………………………………………………………………… ……………………………………………………………………………………………… ………………………………

Have there been any direct consequences from the loss of previous fee revenue, or has this been compensated from other sources?
……………………………………………………………………………………………… ……………………………………………………………………………………………… ……………………………………………………………………………………………… ……………………………….

Part D Drug and equipment supplies

What is the general availability of drugs in this district?
……………………………………………………………………………………………… ……………………………………………………………………………………………… ……………………………………………………………………………………………… ………………………………

Which important items from the standard drug list are currently out of stock in the district warehouse or at facilities?
……………………………………………………………………………………………… ……………………………………………………………………………………………… ……………………………………………………………………………………………… ……………………………….

What remedial action is being taken?
……………………………………………………………………………………………… ……………………………………………………………………………………………… ……………………………………………………………………………………………… ………………………………

What is the general availability of recommended equipment items in this district?
……………………………………………………………………………………………… ……………………………………………………………………………………………… ……………………………………………………………………………………………… ………………………………

Which items of equipment from the standard equipment list are generally not functional because they are absent or broken?
What remedial action is being taken?
……………………………………………………………………………………………… ……………………………………………………………………………………………… ……………………………………………………………………………………………… ………………………………

Part E Staff attendance reporting

Is it difficult to comply with the requirements for reporting staff attendance to HQ? (Probe)……………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
……………………………

Are there any sanctions for inaccurate or incomplete or untimely reporting? (Probe)
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………

Are the procedures which have been developed for sanctioning unauthorized absences working well?
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………

Part F Management perceptions of salary and working conditions.
(NB. The precise wording of these questions will depend on whether answers are being given by a single individual or a group)
Since January 2011, has the staff in this district received their salaries in full and on time? (Probe)
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………

Since salaries were last upgraded (date to be determined), do the staff believe that they are correctly rewarded for the work they do and the conditions in which they live and work? (Probe)
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………

Do the DHMT/Council regard the existing level of salaries received by health workers in this district to be fair, taking account of the general economic condition of the country and the public service?
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………

In deciding on what is fair reward, which group do the DHMT/Council think it appropriate for health staff to be compared with?
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………

Are there specific aspects of the nature of the work in this district or its location that would justify extra payments to its staff?
....
....
....

Are there in fact any supplementary payments or allowances, additional to basic salary, paid to staff in this district? Enumerate.
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………….

Are staff houses generally provided for health workers in this district? If for some staff, what is their condition? For those staff not in receipt of staff housing, do they receive a housing allowance, and is it adequate to cover the cost of rental? (Probe)
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
………………………………………………………………………………………

Is there suitable schooling available for the children of health staff in this district?
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………….

Part G Fee charging
(Before starting this series of questions, remind the informant(s) that DFID's objective in supplementing salaries was to facilitate the delivery of free MCH services)

For which services are fees charged in this district? Who has authority to determine fees?
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………….

How are fee receipts recorded? Are the amounts collected at facilities known to the DHMT/Council
……………………………………………………………………………………………
……………………………………………………………….

If yes, what is the average monthly fee income for all facilities so far this year? ……………………………….

How is the fee income used?
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………….

Is this expenditure recorded, if so, how?
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

Are there other ways in which those expenditures are financed (deliveries in kind, cash provided by government to the facility)?
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

Are there any services for which pregnant and lactating women can properly be charged? (Probe for exceptional services such as family planning, ambulance, blood transfusion, etc.)
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

Are there any supplies which pregnant and lactating women are asked to bring to the facility because the facility does not have them?
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

Are there any services for children under five which can properly be charged for? (Probe for exceptional items such as the registration card/road to health chart, food supplements, bed nets)
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

How frequently are incidents of fee charging contrary to the FHCI believed to occur? Probe, acknowledging that by its very nature improper fee charging is difficult to prove and is seldom reported
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………………………………………………………………………

Is there a system for recoding and investigating claims of improper charging?
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

How many incidents of improper charging have been alleged since January 2011?
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………..

How many cases of improper charging have been investigated?
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………..

How many health workers have been sanctioned for improper fee charging, and what form have these sanctions taken?
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………
……………………………

To what extent do DHMT/Council members think that salary supplementation has been an effective discouragement to improper fee charging, or have other factors been more important?
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………
……………………………

Close the interview, thanking respondents for their time.

Annex 5 Health facilities questionnaire

Initial explanation of reason for visit, introduction of visiting team members, establish names and job titles of staff met. Assure informants that they will not be individually identified in the report except with their express permission. Discuss how best to conduct visit with minimum interference with clinical services. Propose tour of facilities as means of estimating capacity to deliver services. Interviewer to make notes on number and designation of rooms, condition of buildings, water supply, electricity or other means of lighting, sanitation, medical waste disposal.

Part A. Staffing. Draw up a matrix of staff in post

Job title Grade Number in post Present Y/N Reason for absence Supp allowances?
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
…………………………………………………………………………………………

Part B. Services available at this health facility (place tick against each item in list, probe if not evidently compatible with staffing available).

General outpatients Under-fives clinic Immunisations
ANC clinic Facility delivery Home delivery by clinic staff
BEONC/CEONC status Family planning (list to be refined after consultation with MOHS)
Inpatients

Part C. Utilisation of services. (Ask to see registers and copies of reports to DHMT)

Record numbers seen in last complete month (probably May) and 6 months previously (November 2011) by list of services:

M N	M N	M N
General outpatients	Under-fives clinic	Immunisations
ANC clinic	Facility delivery	Home delivery by clinic staff
BEONC/CEONC status	Family planning	Other
Inpatients		

Is there a defined catchment population or area for this facility? Y/N How is it defined?
………………………………………………………………………………………………
…………………………………………

If not by number of population, ask how many people (approximately) live in the area served? ………………

Part D Drug and equipment supplies

Which items from the standard drug list for this type of facility are currently out of stock? (Review actual stock against list from MOHS)
What remedial action is being taken?
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

Which items of equipment from the standard equipment list for this type of facility are currently not functional because they are absent or broken? (Review against list from MOHS)
What remedial action is being taken?
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

Part E Staff perceptions of workload

Is this facility adequately staffed for the services currently provided and numbers of patients attending?
(Probe)……………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………

Are the catchment population receiving the number and type of services they need? (Probe)
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

What are the main issues that stop more people from using the existing services? (Probe)
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

What are the main problems that stop the health facility from offering more and better services? (Probe)
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

Part F Staff perceptions of salary and working conditions. (NB. The precise wording of these questions will depend on whether answers are being given by a single individual or a group)

Since January 2011, has the staff at this facility received their salaries in full and on time? (Probe)
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

Since salaries were last upgraded (date to be determined), do the staff believe that they are correctly rewarded for the work they do and the conditions in which they live and work? (Probe)
……………………………………………………………………………………………
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……………………………

In deciding on what is fair reward, which group do the staff wish to be compared with?
……………………………………………………………………………………………
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Are there specific aspects of the nature of the work in this facility or its location that would justify extra payments to its staff?
……
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…………………………………………………

Are there in fact any supplementary payments or allowances, additional to basic salary, paid to staff in this facility? Enumerate.
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………….

Are staff houses provided at this facility? If for some staff, what is their condition? For those staff not in receipt of staff housing, do they receive a housing allowance, and is it adequate to cover the cost of rental? (Probe)
……………………………………………………………………………………………
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Is there suitable schooling available for the children of staff at this facility?
……………………………………………………………………………………………
……………………………………………………………………………………………
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…………………………….

Part G Fee charging (Before starting this series of questions, remind the informant(s) that DFID's objective in supplementing salaries was to facilitate the delivery of free MCH services)

For which services are fees charged at this facility? (Check against list of services)
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

How are fee receipts recorded? (Ask to see receipt book or ledger)
………………………………………………………………………………………………
……………………………………………………………

What is the average monthly fee income so far this year?
………………………………………..

How is the fee income used?
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
……………………………

Is this expenditure recorded, if so, how? (ask to see records if they exist)
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

Is there any other way in which those expenditures could be financed (deliveries in kind, cash provided by government to the facility)?
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

Are there any services for which pregnant and lactating women can properly be charged? (Probe for exceptional services such as family planning, ambulance, blood transfusion, etc.)
………………………………………………………………………………………………
………

Are there any supplies which pregnant and lactating women are asked to bring to the facility because the facility does not have them?
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
……………………………

Are there any services for children under five which can properly be charged for? (Probe for exceptional items such as the registration card/road to health chart, food supplements, bed nets)
………………………………………………………………………………………………
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……………………………

Close the visit with thanks to the informants for their time and trouble.

Annex 6 Exit Survey Questionnaire

(Approach ALL patients leaving the health facility, but if there are several leaving at the same time, concentrate on mothers with small children or single females of reproductive age. Introduce yourself on the lines of: My name is ……………………… from the (name of organization). I would like to ask you a few questions about your experience at (name of health facility) today.

First, establish who the patient was in order to correctly phrase the questions. (Repeat if necessary if there was more than one patient). Then ask:
Which health worker did you see today? (Record the job title)
…………………………………….

How long did you wait at the clinic/hospital before you were seen? Less than 15 minutes/15-30 minutes/ 30-60 minutes/ more than 1 hour/ more than 2 hours (Mark the answer given)

Were you prescribed any medication? Y/N
Did you receive this medication at the clinic/hospital? Y/N

If no, can you give the reason?
…………………………………………………………………………………….

How satisfied were you with the treatment you/your child received at the clinic/hospital today? Fully satisfied/ fairly satisfied/ not satisfied (Mark the answer given)

(For those who were not fully satisfied, ask:)
Why were you not satisfied/not fully satisfied with the treatment?
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

How did you travel from your home to (name of facility) today? Walk/car/minibus
If appropriate ask, how much did you pay for transport (one way)? Record amount in Leones ……………….

Did you pay anything at the (name of facility)? Y/N

If yes, how much did you pay? Leones……………………………………..

What was the reason for payment?
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………

In general, do you think services at (name of facility) have improved over the last two years?
……………………………………………………………………………………………
…………………………………………………………………

Conclude interview by thanking respondents for their time

Annex 7 Payroll data collection tool

Targets		Source of information	Ranking
Progress			
1	Progress made against project implementation roadmap		
Project Governance and Resources			
2	Sufficient human and financial resources are in place to ensure successful oversight and delivery		
User Involvement and User Specifications			
3	Users in the Districts, MOHS and AG have sufficiently been involved in the project and their interests reflected in the system design and specifications		
Capacity Building			
4	Sufficient and trained personnel are able to operate the payroll system after technical assistance and to take eventual ownership of the payroll system		
Economy Objectives			
5	Removes duplication of multiple departments capturing and maintaining the same information (single, common, shared data repository)		
6	Avoids many steps for health workers having to inform multiple departments of desired changes in the payroll		
Efficiency			
7	Has the payroll system improved the quality of service delivery – better information leads directly to enhanced decision-making		
8	Common and centralized data format facilitates access to information, and facilitated development of new initiatives particularly workforce planning and capacity building		
9	Strong data verification has reduced the potential for mismanagement and/or fraud		
10	Very significant process improvements, reduced cycle times and increased accuracy		
Effectiveness			
11	Is the payroll system providing up to date information with greater accuracy, timeliness and relevance to support better decision-making		

Targets		Source of information	Ranking
Progress			
Project Financial Evaluation			
17	Project budget for payroll system accurate, relevant, and well manage		
Project Timeline Evaluation			
18	Payroll project is on-time and progress meets stakeholder expectations.		
Project Quality Evaluation			
19	Software Development		
20	Documentation		
21	Data management		
21	Usability and Reliability		
Project Scope Evaluation			
22	Are all Health workers with Job description and titles managed through the payroll system		
23	Are there delays in accessing health workers in the payroll		
24	Management of payroll amendments i.e. joiners, promotion, transfer, ….,exit (delays, challenges, efficiency gains)		
Project Management Evaluation			
23	Project control methodology and documentation.		
Project Team Structure Evaluation			
24	Project team has all necessary skills/competencies and an appropriate balance of functional and technical skills		
Capacity Development Evaluation			
25	MoHS operational capacities improved		
26	Government operational capacities improved		
27	Gains made by Healthcare Service Commission		
Enabler Process Coverage Assessment			
28	World Health Organisation HRMIS initiative interfaced with payroll –(from documents provided)		

Targets		Source of information	Ranking
Progress			
Value-Add Process Coverage Assessment			
29	Are the WHO initiatives HR management processes provided within payroll system		
Infrastructure Readiness Assessment			
32	Support resources and management tools in place to deal with end-user support and problem resolution		
33	Internet, network connectivity to all locations where payroll system clients exist		
34	Application architecture suitable for large-scale deployment		
Security Readiness Assessment			
35	Physical Security is implemented and maintained		
36	Application Security is adequate to meet additional demands of increased user base at rollout		
37	Database and data security has been stress tested for expected transaction volume		
Disaster Recovery Readiness Assessment			
38	Substantive preparedness to recover from catastrophic failure		
Maintenance Planning Readiness Assessment			
39	Adequate resource and management processes are in place to maintain the payroll application and manage releases of enhancements and bug-fixes		
40	Hardware replacement and redundancy factored in to Government recurrent budget		
Support Planning Readiness Assessment			
41	Adequate tools in place to manage support call analysis, escalation, problem tracking, and resolution		
42	Support resources and capacity sufficient to manage call volume		

World Bank Assessment Matrix

Rating	Description	Scoring	Score Colour
Fully achieved	Where the target output has substantially and evidently been delivered.	A	Green
Substantially achieved	Where the actions have delivered some significant intermediate output.	B	Amber
Noteworthy progress made	Where some activities are monitored but there is no substantial output yet.	C	Yellow
Zero or minimal progress	Where no specific implementation activity can be identified relating to the particular target output.	D	Red

Annex 8 Stakeholders interviewed

GoSL		
MoHS	Mr J T Kanu	Permanent Secretary
MoHS	Dr Kishto S Daoh	Chief Medical Officer
MoHS	Mr Prince Cole	Director of Human Resources
MoHS	Mr Amara S Koroma	Director of Financial Resources
MoHS	Mr Michael M Amara	Principal Health Economist
MoHS	Dr Magbity	Principal M&E Officer
MoHS	Mrs Elizabeth Lemor	Head of HRH SU
HRMO	Mr Koroma	Director
HRMO	Mr Andrew Sorie	Deputy Director Recruitment and Selection
HRMO	Mr Joseph S Odings Brima	Deputy Director Corporate Strategy
HRMO	Mr Amaru A Conteh	Deputy Director Staff Welfare and Employment Relations
MoFED	Mr Matthew Dingie	Budget Officer
Partners		
DFID	Mrs Uzoamaka Gilpin	Health Adviser Sierra Leone & Liberia
DFID	Mr John Paul Fanning	Economic Adviser
GFTAM	Mr Donald Conteh	Head of HSS Unit
UNICEF	Dr Augustin Kabano	Health Manager
WHO	Dr Teniin Gakurah	Health System Specialist
Options	Mr Stuart King	Team Leader
	Mr Sam Tapera	TA HRH
	Dr Ladi Sotimehin	TA RCH
	Mr Alhassan Kanu	RHSS Specialist Northern Region
	Mr Momodu Sesay	RHSS Specialist Western Region
	Sr Hawa B Kargbo	RHSS Specialist Southern Region
CGA	Ms Erin Chu	Team Leader
	Ms Judith Caine	Technical Advisor
	Mr Philip Lee	IT Specialist
	Mr Mohammed Ali	TA M&E Systems
Facility Interviews		
Bombali DHMT	Management Team	DMO
Bombali District Council	Mr Mohammed O Mumah	Chief Administrator
Makheni DH	Mrs Fatmata Kannah and Team	Management Team
Kamabai CHC	Mr Francis Sesay and Team	CHO
Mabankonkani MCHP	Mrs Marie Kanu	MCH Aide
Koinadugu DHMT	Dr A A Sandi and Team	DMO
Koinadugu District Council	Mr Peter B Konteh and Team	Chairman
Kabala District Hospital	Dr F Sesay and Team	Medical Superintendent

Kagbasia MCHP	Mrs Amie Koroma	MCH Aide
Kondemia CHC	CHC Team	CHO
Port Loko DHMT		DMO
Port Loko District Council	Mr Ahmid Munir Fofonah and Team	Chairman
Port Loko DH	Management Team	Hospital Secretary
Gbonkoh Kareneh MCHP	Mrs Miriam M Kamara	MCH Aide
Mafoimoto CHP	In charge	MCH Aide
Western District DHMT	Sr Christiana B Massally and Team	Senior Public Health Nurse
Ola During Childrens Hospital	Dr David E Brown and Team	Medical Superintendent
Haj Neneh CHP	Mrs Lucy Bamoh	In charge
Ginger Hall CHC	Mr Mustapha M Komona and Team	CHO
Bo DHMT	Dr J Mussa	DMO
Bo District Council	Mr Joseph Bindi and Team	Deputy Mayor
Bo Government Hospital	Dr A P Koroma	Medical Superintendent
Guima MCHP	Mrs Alice T Neguyei	MCH Aide
Koribibondo CHC	Mr Vandy Kabba	CHO
Pujehun DHMT	Dr Francis Jayah	DMO
Pujehun District Council	Mr Ali Badara Fofana and Team	Deputy Chief Administrator
Pujehun DH	Management Team	In charge
Gbondopi CHC	Mr Taheru Abdulai	CHO
Bandajuma CHC	Mr Mohammed Savane	CHO
Moyamba DHMT	Mr Victor Carelloms and Team	In charge
Moyamba District Council	Mr Ishmael Momoh and Team	Deputy Chairman
Moyamba DH	Management Team	In charge
Gandorhun CHC	Mr Paul A Kpandon	CHO
Taiama CHC	Mr Brima A Gamanga	CHO
HFAC	Mr Anthony Sesay	N Regional Administrator
HFAC	Mr Alfred Turay	N Regional M&E Officer
HFAC	Mr Peter Bandura	Bombali District Coordinator
HFAC	Mr David J Allieu,	E Regional Administrator
HFAC	Sheku Kanneh,	S Regional M & E Officer

Annex 9 District level interviews

Northern Region	
Bombali District	Bombali DHMT
	Bombali Local Council
	Makheni Government Hospital
	Mabonkani MCHP
	Kamabai CHC
	HFAC District Coordinator, Bombali District
Koinadugu District	Koinadugu DHMT
	Koinadugu Local Council
	Kabala District Hospital
	Kondembaia CHC
	Kagbasia MCHP
	HFAC District Coordinator, Koinadugu District
Port Loko District	Port Loko DHMT
	Port Loko Local Council
	Port Loko Government Hospital
	Gbonkoh-Kareneh MCHP
	Mafoimoto CHP
	HFAC District Coordinator, Port Loko District
Southern Region	
Bo District	Bo DHMT
	Bo Local Council
	Bo Government Hospital
	Guima MCHP
	Kotibando CHC
	HFAC District Coordinator, Bo District
Pujehun District	Pujehun DHMT
	Pujehun Local Council
	Pujehun Government Hospital
	Gbondapi CHC
	Bandajuma CHC
	HFAC District Coordinator, Pujehun District
Moyamba District	Moyamba DHMT
	Moyamba Local Council
	Moyamba Government Hospita
	Gandorhun CHC
	Taiama CHC
	HFAC District Coordinator, Moyamba District
Western Region	
Western Area District	Western Area DHMT
	Ola During Childrens Hospital
	Ginger Hall CHC
	Haja Neneh CHP

Annex 10 Trends in service utilisation

It has proved surprisingly difficult to compile clear evidence of changes over time in the utilisation of health services affected by the FHCI. The published data at national level basically covers 2010 and 2011, with limited data for 2009. Within year changes are not shown, with the exception of quarterly changes within 2009 for under-five outpatient attendances, which reveal a dramatic increase in the second and subsequent quarters following the introduction of FHCI. The reported numbers are:

Q1	Q2	Q3	Q4
270,875	700,289	781,027	696,666

An attempt was made to update the national data for the first half of 2012, to see whether the declines observed in some services had been reversed in 2012. In the event, it was possible to obtain data only for the first two months of 2012. This is reported below, and pro-rated to an annual basis for comparability with preceding annual values, assuming that utilisation remains constant at the rate set in January and February. Although great weight cannot be attached to data for only two months, the picture is rather discouraging, suggesting no recovery from the depressed levels found in 2011.

	2010	2011	Jan/Feb 2012	2012 pro rata
Under 5 OP consultations (000s)	2450	1450 (est.)	244	1467
Hospital delivery (number)	13750	15103	2404	14424
Delivery by skilled attendant	121821	129821	22750	136500
Caesarean section	2634	2350	338	2328

During the course of the field visits in Southern Region, some data on utilisation was collected from certain of the facilities visited. Although this data is extremely fragmented, being collected on a purely opportunistic basis, it does have one advantage---in most cases it was possible to collect data on a month by month basis from January 2010 (before FHCI started) to mid-2012. Discounting some unexpectedly large month by month variations, the trends shown in this data are somewhat mixed. At one extreme (Koribondo CHC, Bo District) there has been a huge and sustained increase in under-five attendances. At the other extreme (Gondorhun CHC, Moyamba District), there has been a consistent decline in ANC attendances and deliveries, though under-five attendances are on an upward trend. One of the more disappointing observations is the trend in Caesarean sections at Bo Hospital, where a decline in fistula cases was attributed to an increase in hospital deliveries post FHCI and increased access to Caesarean sections. This sounded plausible until an examination of the data showed that although there was a weak upward trend in normal deliveries; Caesarean sections had actually declined from 77 in 2010 (which included three and a half months before FHCI) to 61 in 2011 and only 19 in the first six months of 2012. This is in contrast to the situation at Pujehun District Hospital where the corresponding figures are 32, 38 and 29.

It must be stressed that too much should not be read into these scattered observations. They certainly do not support a cheerful conclusion that the very high levels of utilisation experienced in the immediate aftermath of the introduction of free MCH have been consistently recovered in 2012.

Utilisation Statistics Southern Region

	Jan	Feb	March	Apr	May	Jun	July	August	Sept	Oct	Nov	Dec	Total
Koribondo CHC													
Under 5s													
2010	75	56	41		397	256	362	333	255	218	242	233	
2011	205	155	168	231	185	314	490	600	1041	869	931	565	
2012	685	622	720	788	1132	789							
Guima MCHP	32	38	64	98	297	185	332	319	196	241	249	171	
Under 5s	171	186	115	165	252	227	141	101	61	53	98	130	
	158	144	151	139	141	119							

		Jan	Feb	March	Apr	May	Jun	July	August	Sept	Oct	Nov	Dec	Total
Bo Government Hospital														
Maternity ward														
2010	Total admissions	50	45	60	48	176	193	103	122	168	148	120	175	1408
of which:	Normal delivery	8	3	16	16		94	87	65	81	64	62	43	539
	Cesarean section	5	3	3	15	9	11	12	3	8	4	2	2	77
2011	Total admissions	145	116	106123	178	184	152				182	150	132	
of which:	Normal delivery	36	37	47	61	48	66	63	63	56	72	65	21	635
	Cesarean section	5	6	3	2	4	12	4	11	6	6	1	1	61
2012	Total admissions	150	95	105	128	129	110							717
of which:	Normal delivery	71	37	57	62	53	63							343
	Cesarean section	3	0	5	3	5	3							19
Paediatric ward														
2010	Total admissions				34	168	149	132	121	118	43	29	91	
2011		97	85	82	62	81	83	147	136	116	107	81	92	
2012		113	74	96	64	119	108							

		Jan	Feb	March	Apr	May	Jun	July	August	Sept	Oct	Nov	Dec	Total
Bandajama CHC (MSH)														
Deliveries														
	2010	34	30	16	38	23	41	23	27	34	25	27	31	
	2011	19	18	16	25	22	30	27	27	25	34	15	25	
	2012	26	30	31	26	30	28							
ANC attendances														
	2010							200	170	375	441	543	337	
	2011	453	269	347	318	130	175	231	251	185	349	271	296	
	2012	193	228	268	220	318								
Gbondapi CHC														
Deliveries														
	2011			15	15	17	20	13	25	15	18	25	22	
	2012	21	10	14	19	20	21							
Under 5s	2010				301	123	527	242	234	231	160	215	269	
	2011	194	115	116	122	151	140	145	133	82	147	336	113	
	2012	71	136	81	56	124	171							

		Jan	Feb	March	Apr	May	Jun	July	August	Sept	Oct	Nov	Dec	Total
Pujehun Hospital														
Maternity Unit														
2010	Total admissions	15	20	27	37	60	19	30	27	45	40	64	61	
of which:	Normal delivery	5	6	11	10	20	20	17	21	18	18	20	16	
	Cesarean section	2	2	1	2	2	6	1	4	2	4	1	5	32
2011	Total admissions	55	52	66	24	24	63	29	24	20	35	50	71	
of which:	Normal delivery	19	11	18	17	28	22	21	20	19	21	26	21	
	Cesarean section	2	2	7	2	2	1	1	6	0	7	7	1	38
2012	Total admissions	68	68	83	56	70								
of which:	Normal delivery	20	13	26	25	26								
	Cesarean section	de	4	5	10	10								29
Paediatric unit	Total Admissions													
	2010	16	28	18	50	56	160	110	62	61	59	39	42	
	2011	58	109	62	46	59	82	65	74	67	57	35	46	
	2012	34	24	43	46	76	76							

		Jan	Feb	March	Apr	May	Jun	July	August	Sept	Oct	Nov	Dec	Total
Taiama CHC, Moyamba District														
ANC	Total Admissions:													
	2010	64	50	66	57	111	88	65	108	105	102	123	113	
	2011	46	120	208	93	135	71	105	131	94	73	55	44	
	2012	112	70	48	82	57	86							
Deliveries	2010	8	7	2	6	7	10	5	8	3	6	6	4	72
	2011	5	5	5	11	9	8	13	7	5	9	10	14	101
	2012	11	12	5	17	10	16							71
Under 5s	2010	42	48	49	105	274	262	204	121	118	121	81	85	
	2011	82	57	88	98	80	107	98	80	108	71	108	101	
	2012	121	115	154	130	145	243							
Gondorhun CHC, Moyamba district														
ANC														
	2010	119	86	109	104	88	96	98	72	77	61	92	53	1055
	2011	76	77	116	78	63	80	61	59	70	68	77	69	894
	2012	68	70	72	63	69	66							408
Deliveries	2010	24	15	20	21	20	26	16	12	20	20	19	15	228
	2011	18	20	18	20	14	20	18	14	17	9	12	16	196
	2012	20	11	10	12	18	9							80
Under 5s	2010	124	154	27	126	53	93	125	79	110	122	110	92	1215
	2011	89	102	85	130	159	107	175	158	173	164	174	165	1681
	2012	186	166	96	149	208	282							1087

Annex 11 Results from the exit survey

Rationale

When the evaluation team examined the early documents provided on the programme, and specifically the content of the 2011 and 2012 Annual Reviews, they were struck by the apparent absence of information on key topics, one of which was the degree to which charging of target groups was continuing after the formal introduction of the FHCI. At that time, being aware of the role of the HFAC as CSO monitors of health service functions, the team thought that although HFAC staff and volunteers had been trained for the role, they had not in fact performed any monitoring of fee charging. The team therefore proposed as a stopgap measure in the inception report that during the fieldwork an exit survey of patients attending the facilities might be conducted. It was acknowledged that this could only be a small scale and non-random survey, but in the absence of other evidence, it was thought that it might be valuable to carry out such a survey. DFID Sierra Leone agreed.

It subsequently emerged that HFAC had in fact conducted a survey of fee charging in 2011, but its results appeared to have attracted little attention. It reported that 20.4% of under-five and pregnant and lactating women patients had paid for services which should have been delivered free.

Methodology

The exit surveys were carried out in conjunction with visits to 7 of Sierra Leone's 13 districts in the week of 2-7July 2012. The evaluation team divided for these visits, each member being accompanied by a staff member from Options and one or more staff of HFAC. In each district, in addition to interviews with the DHMT and the District Council, visits were made to the district hospital and two PHUs. While the evaluation team members and Options personnel interviewed the staff of each facility, the HFAC staff conducted interviews with patients leaving the facility. The number of patients surveyed at each facility was not pre-determined and varied considerably between hospitals, where patients were numerous at all times of day, and PHUs, where numbers were affected both by the time of day at which the visit occurred and the rains. In some cases where few patients were seen at the PHU, they were followed into the community. The instruction given to the interviewers was that they were to approach as many patients in the target group as possible, but if there were too few in that group, they could also interview patients falling into other groups. In the event, almost all the respondents were from the target groups. The selection of patients was therefore opportunistic, and no claim can be made that respondents were fully representative, even of the target group.

The interviews were conducted using an interview schedule, a copy of which appears at the end of this report. Questions were asked on waiting time at the facility, drugs prescribed and dispensed, degree of satisfaction with services provided, method of travel and time or cost as appropriate, whether or not payment had been made at the facility, and finally, the opinion of the respondent on whether or not improvements had taken place at that facility over the last two years. In general, this sequence of questions seems to have worked well, except that a specific category was not provided for travel by motorcycle taxi.

The answers to these questions were coded and entered into an Excel spread sheet. Where necessary to resolve apparently anomalous codes, reference was made to the original completed questionnaires. For some topics, simple counts of observations were taken, but for topics of greatest interest and where the data was thought to be sufficiently reliable, cross tabulations were undertaken. A total of 218

interviews were conducted. All of the forms could be used, though a number of questions were randomly omitted by the interviewers, which meant that the denominator value varies across the questions.

Patient identities

Of the patients concerned, 57 were recorded as pregnant women, 82 as lactating mothers, 62 as under-fives, 8 were outside the target group being adults or older children, and 9 were not stated. It is almost certain that the number of lactating mothers is overstated; the interviewers reported the identity of the person they were speaking to, rather than the patient. Because of the unreliability of this data item, it was not used in cross tabulations.

Waiting time

The question on waiting time was not recorded for three patients. Out of 215 patients for whom waiting time was recorded, 76 (35%) waited under 15 minutes; some of these were seen immediately on arrival. A further 47 (22%) waited for times between 15 and 30 minutes; 25 (12%) waited between 30 and 60 minutes, 24 (11%) waited between 1 and 2 hours before being seen, while a disturbing 43 (20%) waited over two hours.

In general, the longer waits were associated with hospital attendance, as shown in the following tabulation:

	Type of facility		
Waiting time	**Hospital**	**PHU**	**Total**
Less than 15 minutes	28	48	76
15-30 minutes	19	28	47
30 60 minutes	18	7	25
More than 1 hour	16	8	24
More than 2 hours	36	7	43
Not stated	3	3	
Totals:	**117**	**101**	**218**

Respondents were asked if they knew the reason why they waited. Numbers and percentages are affected by the very high number of respondents whose answer was not recorded. In almost all cases the non-response applied to patients who had reported a very short wait, so it may be assumed that either the question was not put to them because it was deemed inapplicable, or their answer was that they did not have to wait. As expected, the most common reason given was that the patient had queued behind other patients. About 8% of respondents gave a variety of other answers to this question, including the preoccupation of health workers with other duties (this included preparation for, or receiving, the evaluation team!). In only two instances was the absence or late arrival of the health worker blamed for the wait.

Medication received

Of the 218 respondents, 204 were prescribed medicine. Of these, 166 (81.4%) received all that they were prescribed, while 35 (17.2%) received only some or none of the items on their prescription. The balance was 2 cases in which the information was not recorded and 1 case where the information was unclear. In the cases where medicine was prescribed but not received, interviewers were instructed to probe for the reason. In 31 cases, it was stated that the drugs were not available at the facility.

Of these, 25 cases related to hospitals, only 6 to PHUs. In another 4 cases, patients were asked to pay for the medication prescribed, which by implication they were unable or unwilling to do. The implications of these findings will be discussed further in the context of fee charging.

Level of satisfaction with services received.

Respondents were asked to say whether they were fully satisfied, partially satisfied or not satisfied with the service they had just received. Only 14 described themselves as not satisfied, and a further 24 as partially satisfied, while 180 or 82.6% regarded themselves as fully satisfied. These are rather surprising results given factors such as waiting time, unavailability of drugs, and fees paid. There is some correlation between these factors and expressed dissatisfaction, and also with opinions on improvements at the facility over the preceding two years. A full treatment of these associations will be deferred.

Travel time and cost

Questions were asked on the mode of travel to the facility. If they walked, respondents were asked how long it took; if they arrived by vehicles of any type, they were asked how much it cost. Fully 157 (%) walked to the facility, and a further 14 (%) arrived by a combination of walking and vehicles. Motorcycle taxis brought 36, cars (mostly taxis) 9, and 2 were transported by minibus.

Of those who walked, including those using a combination of travel means, the distrib ution of time taken was: 54 took less than 15 minutes, 32 took 15-30 minutes, 31 took 30-60 minutes, 38 took over I hour and 14 took over 2 hours to reach the facility. The average time taken, assuming a mid-point of each time period and 2.5 hours for the upper bound, was 48 minutes.

The range of cost for those who travelled by a vehicle was from a low of Le 1000 to a high of Le 30000, but the great majority of fares were grouped around the low end of this range.

Fees paid

Some charging of target patients was encountered, but the distribution was not uniform. Fee charging or the demand for payment was highest in Western Areas, followed by Northern Region, with few cases in Southern Region. Intimidation of patients occurred at one facility in Northern Region, so these results may understate the true level of charging of MCH patients. The results are summarised as follows:-

	Paid	Did not pay	Total
Target groups	39	162	201
Not stated	2	7	9
Other (non target patients)	5	3	8

Counting only the clearly identified target groups, 39/201 or 19.4% were charged for services which should have been free. If, as seems likely, the majority of those whose identity was not stated were in fact in the target group, the proportion charged is 41/210 or 19.5%. Of those improperly charged, including the presumptive 2 whose identity was not stated, 22 attended hospitals and 19 PHUs (almost exactly in proportion to total attendances). In addition, hospitals legitimately charged 5 who were either adults or older children, but did not charge another 3 of the non-target group.

The lowest fee encountered was Le 1000 for a registration book, and the highest was Le 140,000 for the purchase of blood. Other high fees encountered were Le 87,000, 2 charges of Le 80,000 and one of 70,000, all for blood. The highest fee for drugs was Le 60,000. Another high charge was Le 50,000+ (the patient did not know the precise amount, since the payment was made by her husband).

The reasons given for charging are particularly interesting, given that in the interviews with health managers and staff questions were asked about the possibility of legitimately charging MCH patients for items which might be regarded as marginal to the service. These items included blood and registration books. Health managers and staff were adamant that there were no items for which charges could legitimately be made to the target groups. They did all acknowledge that if an item was not available, such as an ambulance or a specific drug, the patient would be advised to obtain it elsewhere at their own expense, but this would preserve the technical rule that no money would be collected by the facility from MCH patients. The responses to the question seeking to establish for which items payment had been made showed that the most frequent payment was for drugs, discussed further below, but included payments for blood on 4 occasions, injections 5 times, drips 2 times, and on 1 occasion for a registration book, plus various combinations of these items. Sometimes the payment was not for the therapeutic substance itself, but the means for delivering it. In one case payment was for the injection needle, in another for blood transfusion equipment, and there were two references to the purchase of cannulae. One patient was clear that she had paid for "more attention", while another pregnant woman who had a stool test paid Le 2000 and was recorded as saying "This money was [paid] in a form of compensation".

Roughly a third of charges were made in respect of drugs. The high proportion of patients for whom the item purchased was not recorded makes sophisticated analysis of items pointless. Both some of those patients who had received all the drugs prescribed (but presumably wished for something more) and some of those who not had received all of the prescribed drugs ended up paying for additional drugs at the facility. The implication in the first case is that there existed better drugs than included in the standard free MCH stock, and in the second that the item prescribed was not available from that stock. There were in fact a number of references to paediatric formulations not being available.

Since these drugs were available for purchase at the facility and were not purchased outside, the question that is raised is how they were sourced. There would appear to be three logical possibilities: they were drawn from the stock of free MCH drugs, but the patient was told that they were not available from that source; they were drawn from the stock of cost recovery drugs, though a number of facilities denied having received cost recovery drugs, ever or recently; or they were purchased by health workers with the intention to sell on to patients. Each of these routes appears to involve a breach of the rules on free MCH services with which both managers and health workers were completely familiar.

The choice of items to be charged for, and the arguments made for charging, suggest that health workers were aware that they were acting in breach of the policy in making charges, but they were exploiting the imprecision regarding the boundaries of that policy.

Opinion on service improvement

Respondents were asked whether they thought services at the facility they attended had improved over the last two years. 176 (80.7%) thought services had improved, and a further 31 (14.2%) thought they had improved but expressed reservations, usually about the availability of drugs. Only 9 (4.1%) thought the service had not improved, while 2 did not answer this question.
Although the questions were different, it was anticipated that there would be some overlap between those who were dissatisfied with their immediate experience and those who took a negative view of any improvement in services at the facility. It was also anticipated that there would be a correlation with two chief sources of complaint: the unavailability of drugs, and charges. The following tabulation and text explores these associations:

Opinion on improvement over 2 years

Satisfaction	Positive	Qualified	Negative or NS
Fully satisfied	163	13	4
Partially satisfied	10	11	3
Not satisfied	3	7	4

As expected, these observations cluster on the diagonal; those who were satisfied with their current experience were also likely to express a favourable opinion about improvement over the preceding two years. There was a greater scatter of the much smaller number of respondents who expressed negative views. This may be attributable to their ability to distinguish objectively between their own experience and the overall performance of the facility; it may also be a reflection of the anomalous results which provoked some surprise in the evaluation team.

Both positive and negative views tended to revolve around three issues: the fact that services were free, or payment was demanded; the attitude of staff towards patients; and the availability or otherwise of drugs. This is brought out in some of the positive views as recorded by the interviewers: "I thank God and government because before I used to pay but now I don't pay for any treatment" and "At any time I come with my child they attend to me with respect and care". Similar themes echo in the negative judgements. A woman who brought her child thought that there had been no improvement at the facility because "They always demand money from me". Asked why she was dissatisfied, she said "Because I did not buy the drugs they did not talk to me nicely. I came to the hospital without money. I had to return home without attention to my child". A pregnant woman, who waited upwards of 2 hours before being seen, said "When I don't give them money they don't give me the appropriate treatment I need and deserve" and on the same theme "No improvement has taken place yet in this hospital because most of the in-charges are demanding for money".

To test the assumption that negative views would be associated either with not being dispensed all the drugs prescribed, or with being charged, all the interview forms were manually assessed and classified on four axes: degree of satisfaction (3 levels); opinion on improvement (3 positions); whether or not payment was made; whether or not all prescribed drugs had been received. This combination of categories yields a matrix of 36 cells, but more than half the entries were in a single cell---that for those respondents who were fully satisfied, had a positive view of improvements, who were charged nothing and who received all the prescribed drugs. Across the entire survey, 124/218 (56.9%) respondents fell in this category. There were regional

differences: in Southern Region, it was 52/84 (61.9%) but in the combination of Northern Region and Western Areas it was 72/134 (53.7%). The expected associations with payment were found, for example, of those who expressed themselves as fully satisfied but felt no improvement had taken place in their facility, all four had made payments, and 3 of the 4 who both were not satisfied and had negative opinions on improvement had made payments. Similarly with the receipt of prescribed drugs, of those who expressed themselves as not satisfied, 9 had not received all prescribed against 4 who had. But there were also some unexpected findings. There was a large group of 27 respondents who were fully satisfied, thought services had improved, but had paid for drugs or services. Of these, 24 received all drugs prescribed, as against only 3 who did not. What this may suggest is that there exists a significant group of patients who are content if they receive the drugs prescribed, even if this involves payment; payment per se was not a cause of dissatisfaction to this group.

Those who held more qualified views on either satisfaction or improvement most frequently referred to the shortage of drugs as the factor which influenced their withholding an outright endorsement. Other issues for this group included the attitude of health workers, and at one hospital, the failure to maintain the patient toilet. In addition to the expected pattern of responses there were some anomalies. One contradictory response could not be resolved even on a full reading of her questionnaire. This was a mother of an under five child who reported that she was not satisfied, despite the fact that she received all the prescribed drugs, made no payment, and acknowledged that "There is good and great improvement because we are not paying". But the reason she gave for her dissatisfaction was "Because at times not all the drugs are given to us". A more explicable dissonant response, a woman who declared herself fully satisfied as she had received all prescribed drugs on that day, nevertheless took a negative view on improvement because "Most times they tell me drugs are not available".

Koribondo CHC

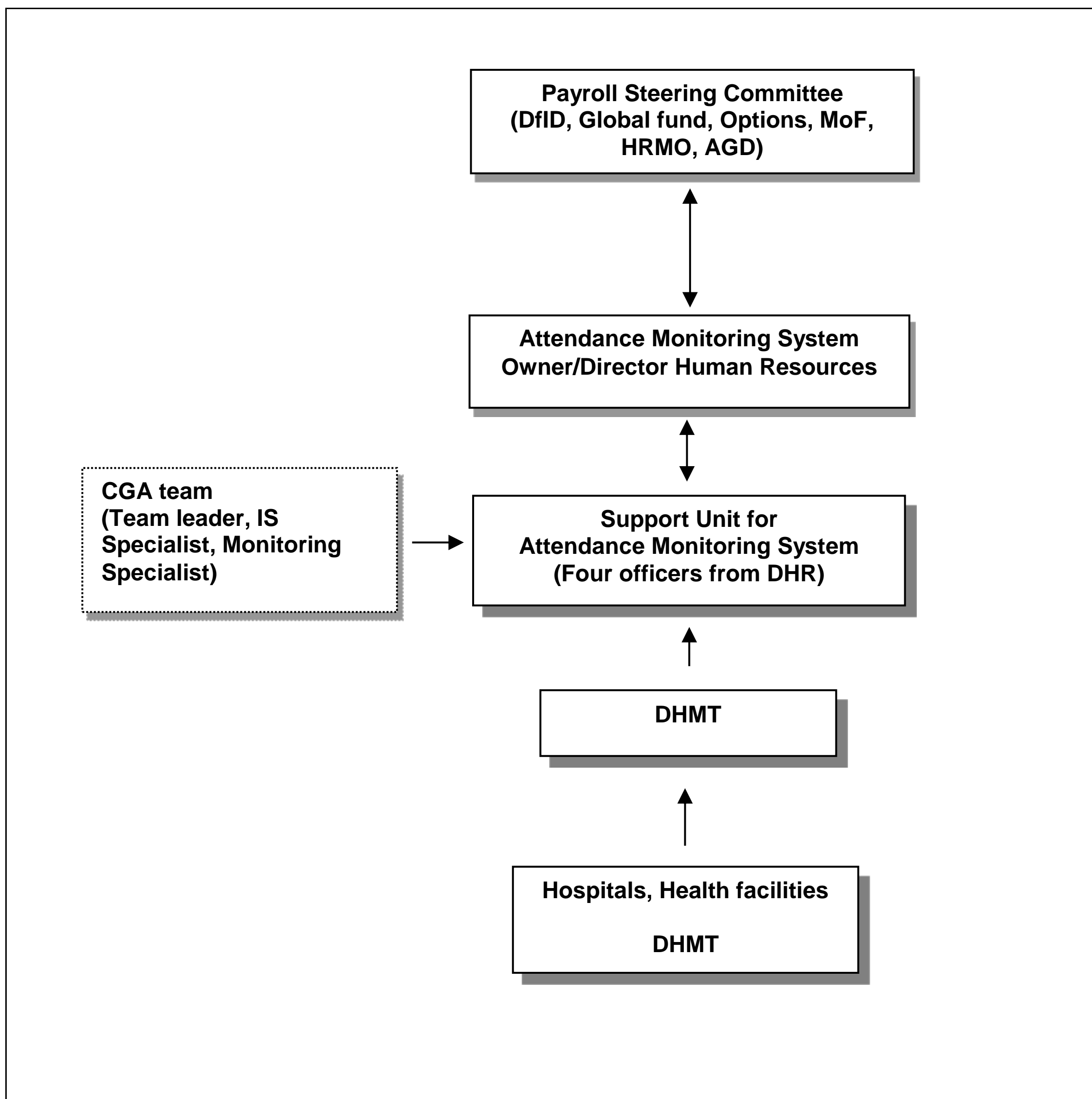
This report has scrupulously refrained from identifying the facilities at which there were apparent shortcomings in the delivery of free MCH services. However, this CHC can be awarded a commendation for the universally favourable views expressed by the 5 respondents who attended there. All were fully satisfied, impressed with improvements over time, no-one paid and all received their prescribed drugs in full. Comments included: "Very good because treatment and drugs are given to us" and "they have good reception and the CHO and his team are very good personnel". Another reported that she lived in Bo but made the journey to Koribondo (17 miles) because "Always no drugs are available [in Bo] and Koribondo are caring". She also said "The facility is clean and the health personnels encourages patients and they know how to talk any body, age or sex".

It might be added that the CHC made a favourable impression on the evaluation team member visiting, and its under-five attendances show a huge and sustained increase since the introduction of the FHCI. This is a facility whose staff deserves congratulations on their faithful execution of the FHCI.

Annex 12 Performance indicators July 2012

				January 2012		July 2012	
	Indicator/Trigger (in bold text)	**Measure**	**Responsible**	**Target**	**Actual**	**Targets**	**Actual**
Group 1							
1	Percent of staff with a job designation (Source: AG payroll)	%	HRMO MoHS/AG	100%	100%	95%	99.7%
2	Percent of Staff with a defined workstation who are on the payroll (Data source: MoHS staff list against payroll)	%	HRMO MoHS/AG	98%	98.8%	80%	83.6%
3	Percent staff with a job designation that matches their grade (Data source: Payroll)	%	HRMO MoHS/AG	97%	97.0%	95%	97.3%
4	Percentage of staff reported to be on study leave with authorization from HRMO	%	HRMO /MoHS			5%	20.2%
Group 2							
5	Percent districts and hospitals report attendance for the month 0 by the end of the month 1	%	MoHS - Districts and Hospitals	100%	96%	100%	98%
6	Percent of facilities report attendance to district (i.e. attendance is captured in monthly tool)	%	MoHS - Districts and Hospitals	90%	98%	90%	96.6%
7	Percent monthly attendance sanctions from MoHS correctly processed by AG/HRMO	%	MoHS/AG/HRMO	98%	69% to 79%	95%	99.6%
8	Percent of attendance process and monitoring visits completed (includes check on physical presence of staff and confirmation of attendance process).	%	MoHS – DPI/HRH and HRMO	90%	160%	75%	162.5 %
Group 3							
9	Number of staff sanctionable (identified by MoHS) for non attendance based on approved framework	no	MoHS	n/a	36	n/a	70
10	Percent unauthorized absenteeism (absent = staff with one or more unexcused absence or whose workstation location is unknown).Total divided by payroll numbers.	%	MoHS	<10%	6.2%	n/a	2.7%
10a	Percent of working days lost to reported unauthorized absenteeism. this measures total unauthorized absence days divided by total expected (21) working days	%	MoHS		3.9%	n/a	1.0%
11	Percent of health cadres completed and finally approved by Government for Revised Scheme of Service	%	MoHS/ HRMO			n/a	0.0%

Annex 13 Governance structures



Annex 14 Health Services Commission

The Health Service Commission Model

Other countries which have created bodies similar to the Health Services Commission (HSC) have generally pursued one of two models. In the first, the aim is to establish an executive agency to manage health service delivery, leaving the much reduced central Ministry of Health to give overall policy direction and interface with the political system, as in the UK. An incidental effect of this model is that health workers cease to be civil servants but become employees of the executive agency. In the second model, the aim is to set up a body parallel to the Civil Service Commission dealing exclusively with the health workforce. In this case, the primary motivation has been two-fold: to escape the stultifying effects of extreme centralisation of procedures related to the appointment, promotion and discipline of health workers in the hands of the HRMO (or equivalent) and the Civil Service Commission; and to enable the payment of salaries and allowances to health workers which reflect better than standard civil service terms their labour market situation and working conditions (in practice, to pay doctors more nearly what they think they are worth). Leaders in reform minded Ministries of Health sought the transfer of these powers to a body which would slacken if not remove the constraints which impeded their effective management of the publicly funded health workforce. Ironically, in Sierra Leone the second of these ambitions had already been achieved with the institution in 2010 of separate and greatly enhanced salary scales for health workers before the creation of the HSC in 2011.

Health Services Commission Act

The functions of the HSC include, at section 9 (2)(c) of the Sierra Leone Health Service Commission Act 2011: “appoint the professional staff of Government healthcare facilities and the ministry and determine the remuneration and other conditions of service of the staff” and at 9 (2)(g): “set standards for the training of healthcare providers and ensure compliance with the standards”. However, the powers conferred on the Commission have much wider application than simply to the health workforce. At section 9 (1) it is stated: “The object for which the Commission is established is to assist the Ministry in formulating and implementing policies for the delivery of affordable, accessible and improved healthcare services to the people” which is amplified by further clauses in section 9 (2) to include (a) “assist the Ministry with the implementation of national policies, programmes and projects…” (b) “ensure access by the people to good quality healthcare services” (d) recommend to the Minister the fees ….” (e) assist with the management of the various projects and programmes ….” (f) monitor and supervise the Boards of the hospitals …” and (h) perform such other functions as are incidental to the achievement of the object for which the Commission is established”.

Functionality

The functions of the HSC as laid down in the Act suggest something of a hybrid between the two models enumerated above. It is not confined to human resource issues, but neither are its responsibilities for service delivery clearly differentiated from those of the Ministry. The frequent use of the phrase “assist the Ministry” powerfully suggests the scope for constant friction between the Ministry and the Commission. The Act appears to be weakly drawn, because not only does it fail to define the respective roles of the Ministry and the Commission, it is also completely silent on the position of the HMRO and Public Services Commission, and therefore fails to cancel the existing powers and responsibilities of those bodies. Interestingly, given the shift to decentralised management of health services, there is no mention

of local councils anywhere in the Act. Similarly, there is no mention of the professional councils, despite the powers given to the Commission by section 9 (2)(g). One informant suggested that the Act produced a conflict of laws with the Local Councils Act, the Hospital Management Act, the Hospitals Board Act (though some sections of that were explicitly repealed which suggests that the drafters were not totally unaware of the issue of conflict of laws) and above all with the Constitution in which the roles of the HRMO and Public Service Commission are enshrined. The explanation offered for the laxity in drafting the Act is that it was politically inspired; the same explanation applies to the sweeping powers given in an attempt to remedy many longstanding deficiencies.

The present condition of the Commission stands in pitiful contrast to its sweeping powers. Although the members of the HSC have been appointed and it has met on a number of occasions, it has no independent office and no secretariat beyond the part time activity of the Director Human Resources. Its budget for the current year is Le200M ($46500) which is manifestly inadequate to launch its activities.

Other countries experiences of implementing a Health Services Commission

The experience of other countries is not very encouraging. In Zambia, the attempt to establish an executive agency launched in 1996 rapidly foundered on two main issues. The first was that the attempt to demarcate the respective responsibilities of the Ministry of Health and the Health Board produced constant conflict between the two parties. The second was that the salaries which the Board members and their top managers awarded themselves were so inflated that the Ministry of Finance decreed that they could not be more widely applied to the health workforce. The upshot was that the Ministry reabsorbed the functions and most of the personnel of the Board.

In Zimbabwe, a Health Services Board with the limited powers of the second model was established and several years after its foundation it is still struggling to acquire the resources to fulfil its mandate. It has been forced to delegate a number of functions to the Ministry of Health, and while there is considerable potential for competition over the division of functions between the Ministry and the Board, a cooperative attitude on both sides has thus far averted open conflict. There are unresolved issues, for example the responsibility for sector-wide HRH planning, which may yet divide the two bodies. On the salaries front, Zimbabwe suffered a devastating hyper-inflation of its currency which prompted a major exodus of health workers, especially the most skilled. The situation was stabilised by the adoption of the US dollar and an emergency salary supplementation scheme funded by external donors. What has been exposed by both the Zambian and Zimbabwean experience is that, whatever the formal autonomy of the Boards created, they are totally dependent on the Ministry of Finance for their funding, and are therefore beholden to their funding source for judgements on the affordability of the total wage bill and by extension, the level of reward to specific categories of personnel.

The most successful, and certainly the most enduring, example of a health Board is found in Ghana. The Ghana Health Service was enacted in 1996 and is still in place. It was created as an executive agency which in effect took over virtually all the functions and personnel of the former Ministry of Health, leaving a rump consisting of little more than the office of the Minister himself. The explicit objective of its creation was to facilitate the reforms intended to produce a more effective, flexible and accountable health delivery system. There are some indications of current disquiet: the post of Director-General which fell vacant in April 2011 was being re-advertised as of May 2012, while efforts by the Ministry of Finance to assimilate health worker salaries to a common salary spine (albeit with labour market adjustments) are being resisted by health workers anxious to protect their skill based premiums.

Annex 15 Risk and mitigation matrix

Risk	Impact	Description	Mitigation
1. Ongoing HRIS development strategy	High	HRMIS and AMS focus on same data group and implemented by same personnel. Therefore need to avoid duplication.	Develop strategy for data collection, analysis and implementation to avoid duplication
2. Lack of technical staff in MOPS	High	There are three full time officers at the Directorate who have limited ICT background. Technical support is provided by the TA. This support ends in Dec 2012	ICT directorate involvement in implementation of the AMS
3. Technology failure	High	The system could fail if modified by non-technical personnel. Currently the fixing is carried out the TA	ICT directorate should keep the source code for the AMS
4. Civil Service Reform Programme	Medium	The focus of the CSRP could change /opposing goals	Sustain commitment by MOH,HRMO,AG office
5. HSC	Medium	HSC is an opportunity to fix the problems of recruitment, deployment and training. The policy issues will determine long term system developments and a risk if the focus is not on attendance monitoring	Connecting the dots

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