

# UNBLOCKING RESULTS

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## CASE STUDY

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### Addressing pay and attendance of health workers in Sierra Leone

**Rebecca Simson**

May 2013



Centre for Aid  
& Public  
Expenditure

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Responsibility for the opinions expressed and any errors of fact or judgement remains with the author.

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# Executive summary

Sierra Leone has some of the worst health indicators in the world, with one in six children dying before their fifth birthday and one in twenty women dying in childbirth (World Bank, 2010b). Prior to the introduction of a free health care initiative in 2010, low utilisation of health clinics suggested that part of the problem lay in the poor quality and high cost of services. Despite 70% of the population living below the poverty line, a study from 2008 showed that two-thirds of all spending on health in Sierra Leone was private out-of-pocket spending, and households reported cost as a major barrier to access (World Bank, 2010a).

The problem of low health care utilisation in Sierra Leone is in part rooted in weak governance of the health sector. Insufficient, unpredictable and heavily earmarked resource flows down to the facility level, combined with poor staff discipline, resulted in inefficient health facilities that relied heavily on user charges. These immediate causes of low health care utilisation in Sierra Leone can be classified according to a framework of common governance constraints to service delivery in developing countries developed by Booth (2010) and Wild et al. (2012). Policy and institutional incoherence is apparent in a lack of coherence between the official responsibilities of health clinics and the limited human and financial resources at their disposal to carry out these functions. Weak top-down performance discipline is manifested in a high rate of staff absenteeism and a shortage of official mechanisms to sanction poor health worker performance. Lack of discretionary resources and little bottom-up accountability has limited the space for local problem solving at the facility level.

The government, with donor support, sought to address some of these constraints to health care access through a large health reform in 2010 that made health care free for children, pregnant women and lactating mothers. This initiative was spearheaded by President Ernest Bai Koroma, who personally pledged to improve Sierra Leone's health care system when he came to office in 2007. Free

health care had been decreed before in post-conflict Sierra Leone, but with limited impact on actual facility fee-collecting practices.<sup>1</sup> The president and other senior government officials recognised that free health care would not be implemented in practice unless they addressed resource constraints at the facility level. Human resource issues were particularly pressing, as understaffing, low wages and weak accountability were resulting in absenteeism, ghost workers on the payroll and reliance on user fees to top up salaries.

Recognising the opportunity to strengthen accountability alongside expansion of the health payroll, the UK Department for International Development (DFID) agreed to finance a proportion of the expanded health wage bill on the condition that the government maintained the integrity of the payroll and tackled the thorny issue of staff absenteeism.

With DFID and, later, Global Fund support, the Ministry of Health and Sanitation (MoHS) has sought to strengthen top-down performance discipline by establishing an attendance monitoring system that records the daily attendance of all health sector employees, penalises unauthorised absences and removes inactive staff from the payroll. This monitoring system has had some immediate effects on staff discipline. Both managers and health workers have voiced appreciation for the system: managers feel discipline has improved because of a mechanism to enforce staff attendance, and staff report that they appreciate the increased fairness and accountability this system has brought.

However, this intervention rests on a principal-agent model that assumes principals at the centre of the government, notably MoHS, the Human Resource Management Office (HRMO) and the Accountant-general's Office, are motivated to hold health workers (their agents) to account. While the

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<sup>1</sup> In 2002, a Presidential Decree was issued that exempted a number of vulnerable groups (including pregnant women, lactating mothers and children) from fees for health care.

president's drive to deliver free health care has generated attention to health worker performance during the start-up phase of the initiative, it remains to be seen whether this top-down drive for discipline will be sustained. Furthermore, the system is reinforced by externally scrutinised salary support conditions, and, as salary support is phased out, this scrutiny will weaken.

This aid intervention thus throws into relief the advantages and disadvantages of working to improve governance conditions at the sectoral level. In this instance, there was strong political will to demonstrate results in the health sector, at least over the short term. However, concern remains as to whether these gains can be sustained in the absence of government-wide institutional change.

# 1

# Introduction

This case study forms a part of a larger ODI research project on aid and governance, the findings of which are summarized in the synthesis report, *'Unblocking results: using aid to address governance constraints in public service delivery'*. It is one among four case studies of aid packages (covering Sierra Leone, Tanzania and Uganda) that appear to have been effective in addressing governance constraints to service delivery.

The development community has long recognized that weak governance and incentive problems hinder the delivery of broad-based public services in developing countries (Keefer and Khemani, 2003; World Bank, 2004; Collier, 2007), and the last decade has seen a growth in research that seeks to understand and diagnose the nature of these governance problems. In particular, this research builds on earlier ODI research by Booth (2010) and Wild et. al. (2012) that categorize typical constraints and incentive problems to service delivery and show that a number of common constraints underlie much of the variation in service delivery performance in developing countries.

However, there is little evidence on whether and how well aid can help to address these governance problems. Research that does exist tends to focus on the impact of specific types of accountability structure on service delivery, rather than the design and delivery features of aid programmes that are necessary to address such constraints. This research project begins to address this gap in the literature by studying the interaction between constraints and aid packages in particular country contexts. This research is exploratory and the findings should be treated as preliminary. It does not aim to evaluate the programmes against their stated objectives, nor measure their impact. Rather it considers whether the aid packages appear to have addressed the governance constraints and, if so, what enabled this in practice.

The case studies were selected after a set of interviews with governance specialists from a range of donor agencies. Participants were asked to name projects that they thought had been particularly effective in addressing common governance constraints. This long list of projects was narrowed down after a desk review of the available project documents and an assessment of their relevance to common governance constraints.

UK Department for International Development (DFID) and the Global Fund support to health worker pay and attendance monitoring in Sierra Leone is an interesting example of a donor-supported initiative to increase performance discipline in an otherwise weakly disciplined civil service. Furthermore, the intervention was undertaken in a context of strong political support for health care reform, thus politicians and health sector managers had a vested interest in ensuring health workers performed their duties.

This paper is organised as follows: Section 2 describes the political context and service delivery constraints pre-intervention. Section 3, on the intervention design, describes the project activities and theory of change. It analyses how the intervention appears to have addressed governance constraints and discusses the persuasiveness of the theory of change and the challenges encountered in practice. Section 4 concludes with broader lessons for aid design.

# 2

# Political context and service delivery constraints

## 2.1 Political context

Sierra Leone emerged from a decade-long civil war in 2002 with some of the worst development outcomes in the world. The country had among the highest rates of child and maternal mortality globally, with one in six children dying before their fifth birthday and one in twenty women dying in childbirth (World Bank, 2010b).

While the Sierra Leone's People's Party (SLPP), elected in the first post-war election in 2002, is widely credited with consolidating peace and stability, there is a widespread perception that it failed to make progress in terms of rebuilding state institutions for service delivery (Wyrod, 2008; Robinson, 2008). The SLPP was voted out of power in 2007 in a close and contested election to the All People's Congress (APC), which vowed to improve the government's service delivery record. Demonstrating decisive action in the health sector and reducing high rates of maternal and child mortality were among the president's top priorities when he assumed office in late 2007 (Donnelly, 2011).

However, the nature of Sierra Leone's political settlement severely hinders the government's ability to provide broad-based public services. The country's fragile political settlement rests on political leaders' ability to placate elite coalitions and the patronage networks these elites command (Brown et al., 2006). This unstable settlement has resulted in weak institutions and weak trust among actors, fostering disorder and discretion as those involved gain from their ability to help others

navigate an unpredictable and opaque system. Weak trust has also resulted in a highly centralised system of rule (Robinson, 2008).

These incentive challenges greatly inhibit government action, even where the political incentive to demonstrate progress is strong. Furthermore, research shows that, in public sectors constrained by these incentive challenges, governments find it particularly hard to improve services such as health care that are transaction intensive and require local discretion and innovation (Pritchett, 2012).

Evidence of the state's weak ability to provide services is apparent in the Sierra Leonean health sector, which has demonstrated very low utilisation of services. Estimates suggest that, in 2008, primary health units treated on average only six to nine morbidities per day (Ensor et al., 2008). Household survey data suggest people visited a health care provider on average only once every two years (World Bank, 2010a). As a result of low utilisation, unit costs were high.

The immediate causes of the health sector's poor performance before the introduction of free health care to a large degree conform to a set of common governance constraints to service delivery classified by Booth (2010) and Wild et al. (2012). We discuss below three typical governance constraints in the context of health care delivery in the period before the introduction of the free health care initiative: (i) policy and institutional incoherence; (ii) weak performance discipline; and (iii) limited space for locally anchored problem solving.

## 2.2 Degree of policy and institutional coherence

Sierra Leone's health sector has historically been characterised by policy and institutional incoherence, exacerbated by high reliance on aid, which accounted for almost half of health expenditure in 2008. Of particular note has been the disconnect between official roles and responsibilities across the chain of government and the framework for financing these functions.

Despite the official decentralisation of primary and secondary health services to district level in the Decentralisation Act of 2004, the Ministry of Health and Sanitation (MoHS) has continued to manage a substantial share of the resources for primary and secondary care, and human resource management remains centrally administered (World Bank, 2010a). Peripheral health units and district hospitals are funded through district councils, but their releases tend to arrive late in the fiscal year and the amounts disbursed are unpredictable, which significantly inhibits planning at the local level. In 2007, district councils received only 40% of their budgeted amount (*ibid.*).

Similarly, medicines, which are procured centrally and distributed to district medical stores, were received only in the second half of the fiscal year, and the cost recovery system for drugs (40% of the value of the drugs had to be levied from patients and returned to the medical stores) broke down in 2006/07 (Ensor et al., 2008). As a result, facilities have frequently resorted to purchasing drugs on the local market for onward sale to patients.

Furthermore, aid resources have contributed to horizontal inequities. A 2008 health financing study found that donor funds were disbursed inequitably in geographical terms, with a 30-fold difference between per capita aid spending between the highest and lowest receiving districts (*ibid.*).

Policy incoherence at the facility level, particularly opaque fee structures, also appear to have deterred health clinic attendance, with no country-wide guidance on fee structures and practices varying between health facilities. A 2002 Presidential Decree to make health care free for vulnerable groups was widely flouted and was inconsistent with the medicines policy, which required facilities to recover a proportion of the costs of drugs. Furthermore, the multitude of different charges for consultations, tests, medicines or nights in hospital has made it difficult for users to predict the final cost of health treatment.

## 2.3 Extent of effective top-down performance discipline or bottom-up accountability mechanisms

Weak performance incentives and discipline have affected the quality of health care. Absenteeism was a major concern prior to the free health care initiative; a 2008 survey found 18% of surveyed clinics were closed on inspectors' arrival, and an average of only 71% of staff positions filled (IGC, 2011). In interviews, health workers cited staff absences as a major obstacle to service delivery, and managers at the facility level lacked the authority to sanction absence or other poor performance.<sup>2</sup> Furthermore, the central government has struggled to enforce the mandatory duty station rotations for health workers, as staff have often resisted the transfer and simply remained in their old duty station, resulting in inequitable geographic distribution of health workers.<sup>3</sup> A study from 2008 found that 84% of all doctors and medical officers were working in and around Freetown, although only 20% of the population lives in this region (World Bank, 2010a).

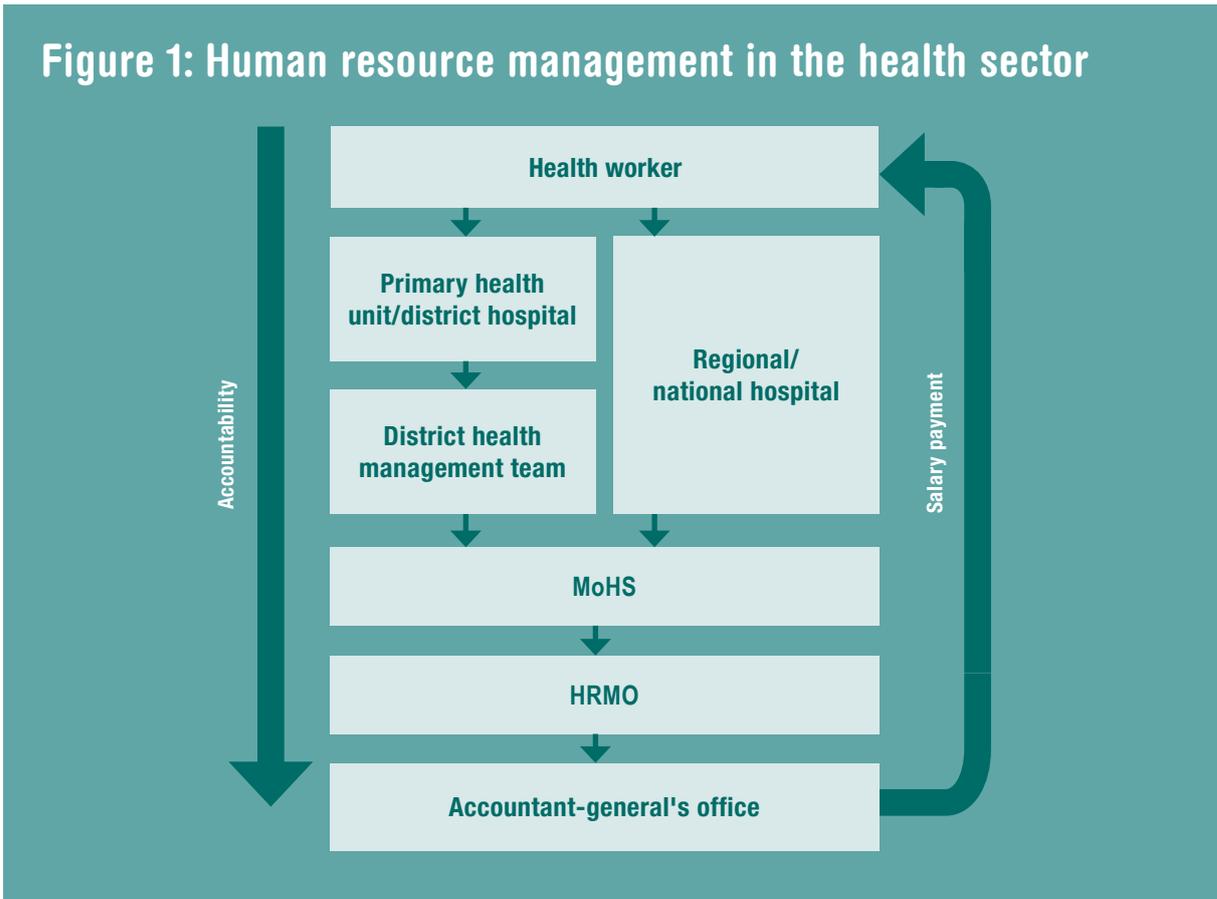
One cause of the lack of effective discipline is that remuneration decisions are taken very far from the facility level where most health workers are supervised. This results in a principal-agent problem, where the principal (the central government) lacks the information to hold health workers (agents) to account. Part of the problem lies in an incomplete process of decentralisation. While in-charges at the health clinics and hospitals are delegated the responsibility for managing their facilities on a day-to-day basis, and districts health teams in turn monitor peripheral health unit and district hospital performance (regional/national hospitals report directly to the MoHS), these managers have limited powers to sanction workers who fail to perform. Despite the decentralisation of primary and secondary health service provision to the district level, recruitment, termination, promotion and wage decisions are managed centrally.

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2 Interviews with staff at three facilities in Bo and Freetown, 17-18 September 2012.

3 Interview with senior government official, Freetown, 14 September 2012.

**Figure 1: Human resource management in the health sector**



In order for a facility in-charge to, for instance, remove a worker from the payroll, he or she needs to escalate this request to the district health management team, which in turn brings the matter to the central MoHS, which then initiates an amendment request to the Human Resource Management Office (HRMO), which contracts all civil servants. HRMO then makes the necessary change to the personnel record and instructs the Accountant-general's Office to make an amendment in the payroll that stops payment going to the bank account of the individual health worker (see Figure 1). The many links that exist in the accountability chain create opportunities for paperwork to go missing or be stalled, whether through interference or neglect.

## 2.4 Enabling environment for locally anchored problem solving and collective action

Research by the Africa Power and Politics Programme suggests that the ability to organise collectively and solve problems at the local level is critical to effective service delivery, particularly when institutional incoherence and

weak top-down discipline mean instructions from the top alone may not have much impact (Booth, 2012).

In part because of the incoherence between the stated responsibilities of health facilities and the official resource flows available to carry them out, before the introduction of free health care, facilities in Sierra Leone resorted to charging fees for consultations, medicines and procedures so they could carry out their basic functions. These discretionary funds at the facility level proved particularly valuable both because they were steadier than official resource channels and because they could be used flexibly according to local needs (Ensor et al., 2008; World Bank, 2010a). Although the lack of transparency in the fee structure and lack of oversight of funds were problematic, these resources provided the facilities with some ability to problem solve locally.

However, health clinics also showed signs of short-termism on the part of managers and workers. A telling indicator is the low investment in maintenance at health facilities: a 2010 spending review found that hospitals had not spent any funds on maintenance, which suggests an inability to act in the facility's long-term interest by preserving assets for the future (World Bank, 2010a).

# 3

# Intervention design

## 3.1 Activities

In November 2009, the president of Sierra Leone announced his intention to introduce free health care for children under five years, pregnant women and lactating mothers. He wanted the initiative to be launched on Sierra Leone's Independence Day on 27 April, less than six months after his announcement. This set in motion a concerted government and donor effort to boost the health care system to enable it to cope with the anticipated rise in demand for services.

Both the government and donors recognised that improving coverage and motivation of health workers would be critical to the success of the initiative. The country had a large deficit in health workers, with many facilities lacking the necessary staff to run facilities, let alone keep them open for 24 hours a day as is necessary to provide comprehensive maternal health services. Furthermore, health workers, and particularly nurses, complained that their pay was insufficient for the increased workloads they were expected to bear as a result of the initiative, and threatened strike action unless salaries were raised. In 2010, a midwife was earning about \$100 per month, which was widely regarded as below a 'living wage'. It was also common to use fees collected at clinics to supplement salaries, particularly for volunteer staff; the government feared it could not induce health workers to waive fees unless they were compensated adequately.

The president actively monitored the recruitment process and helped resolve impasses. After a series of tough negotiations between the nurses union and the president, and a strike a few weeks before the launch of the initiative, the government agreed to substantial pay increases. On average, health technical staff salaries more than tripled according to the MoHS pay-scale.

Aware that the initiative would not succeed without addressing human resources issues in the health

sector, DFID agreed to support this area of reform. Before the government determined health staffing needs and remuneration, DFID financed a payroll cleaning exercise in early 2010 that matched individuals to payroll records and provided a comprehensive picture of staffing coverage at each health facility, including volunteers. As a result of this exercise, 1,500 names on the payroll were frozen,<sup>4</sup> which yielded savings that could be used for new recruits. A rapid and mobile recruitment process was used to bring volunteer health workers onto the payroll, which added 1,200 new recruits.

However, the government, which had not budgeted for the free health care initiative rollout, needed support to finance the significant expansion of the wage bill required to cater for both additional staff and wage increases. DFID agreed to provide budget support for health worker salaries, but did so on the condition that the payroll stayed clean and absenteeism reduced.<sup>5</sup> DFID wanted assurances that its funds were truly financing active health staff. The Global Fund later also agreed to co-finance the wage bill on these same conditions.

To help the government to meet these conditions, DFID also offered a technical assistance programme, bringing back the firm that had conducted the original payroll cleaning exercise to design and support the implementation of an attendance monitoring system.<sup>6</sup> Based on the consultants' recommendations, the free health care sub-committee on human resources agreed to introduce a sanction system for unauthorised absences to address the problem of health worker absenteeism.

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4 Although 1,150 were later unfrozen after the cases had been investigated (Interview and email exchange with Charlie Goldsmith Associates team leader, London, September and November 2012.)

5 In addition to the budget support DFID provided, the government itself financed a large proportion of the increase in health payroll costs.

6 The technical assistance provider was originally Booz and Co., but the role was later taken over by Charlie Goldsmith Associates.

DFID is currently providing £10.3 million in support of health worker salaries over five years on a gradually diminishing basis, complemented by roughly £6 million from the Global Fund from 2010 to date (Stevenson et al., 2012).<sup>7</sup> This is paid out in two-monthly instalments after certification that the government is remaining on track with its human resource management performance targets. These targets are monitored by a payroll steering committee comprising representatives of MoHS, the Ministry of Finance and Economic Development (MoFED), HRMO, DFID and the Global Fund. This meets bimonthly and reviews performance progress and discusses how to overcome any challenges.

In parallel, consultants have been working with the newly established Human Resources for Health Support Unit in MoHS since 2010 to roll out and manage a monthly attendance monitoring system. Each primary health clinic in Sierra Leone now has an attendance register that is tallied by the clinic in-charge, and results are submitted to the district health management team for onward submission to MoHS. National hospitals also register attendance but report directly to the central level. Standardised monthly reporting sheets are co-signed by a member of the community health committee, in order to encourage community involvement and oversight.

On the basis of these data, MoHS prepares the necessary forms for appointing or removing staff from the payroll and freezing the salaries of staff who have unauthorised absences of more than five days in a month. MoHS submits these requests to HRMO, which then reviews the requests and makes the necessary edits to personnel files before instructing the accountant-general to edit the payroll.

The immediate effects of this intervention have been positive. In the year after the introduction of free health care, consultations for children under five years almost tripled compared with the year prior to free health care, and antenatal care consultations increased by 45% (MoHS, 2011). The number of consultations subsequently dropped in 2012, although not to pre-intervention levels. Health workers have therefore seen a substantial increase in their workload. An initial analysis suggests that facilities with better staff attendance are more productive per staff day, as measured by the average number of services provided per working day (Charlie Goldsmiths Associates, 2012).

## 3.2 Theory of change

*'It has not been easy. As President, I believed it was essential for me to take leadership of this from the outset, planning and overseeing its implementation.'*  
– Ernest Bai Koroma, President of Sierra Leone, on the free health care initiative (2012).

The implicit theory of change of this intervention sees health worker absenteeism as a principal-agent problem. The president/politicians are principals who face the challenge of motivating agents (health workers) to act on their behalf in the provision of health services. If the principal has no way of knowing whether or not the agent is carrying out his/her duties, the agent has no incentive to work. The attendance monitoring system rectifies the information asymmetry between principal and agent by providing a reporting system (enforced by MoHS spot-checks) that enables the principal to sanction non-performing agents. This principal-agent relationship is cascaded down the chain of command, with MoHS as the principal to the district health management team, which in turn is the principal to the health facilities and so on.

A second principal-agent relationship exists between the donor (DFID) as principal and the central government as agent. The donor has an interest in the provision of better health care services in Sierra Leone and monitors the agent (central government) to ensure it carries out these contracted duties.

In light of Sierra Leone's presidentially driven delivery agenda, the principal-agent model provides a plausible diagnosis of the relationship between the president, who has staked his political reputation on improving health care, and his self-interested agents at the service provision level, who assume business as usual will prevail. Accounts of the free health care initiative stress the president's political motivations for rolling it out: he used it to demonstrate his commitment to a broad-based national programme without ethnic or regional bias (Scharff, 2012). Similarly, his lack of trust in his agents seems confirmed by his active and hands-on role in planning and monitoring (Donnelly, 2011; Koroma, 2012; Scharff, 2012), which has tackled information asymmetries by keeping agents on a short leash.

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<sup>7</sup> The Global Fund's support falls under a three-year programme, and a second phase to the programme is currently under development.

## 3.3 How the engagement has worked

We can begin to consider the plausibility of the theory of change by examining the effects of the intervention on the three common blockages associated with poor service delivery performance.

### 3.3.1 Degree of policy and institutional coherence

#### Improved intra-sector coherence

DFID-supported pay and attendance support should be seen in the context of the wider free health care initiative in which it was rooted. The free health care initiative provided a concrete and time-bound goal that gave focus to both government and donor activities in the health sector. Both government and donor officials have lauded the collaborative planning process MoHS led during the period leading up to the free health care initiative launch, which ensured broad buy-in and clarity around roles and responsibilities (Donnelly, 2011; Scharff, 2012). DFID's payroll support and the attendance monitoring system grew out of this planning process and complement other health sector investments.

Interviews with health workers confirm that resourcing of the health facilities has improved since the introduction of free health care.<sup>8</sup> In particular, adding volunteer workers to the payroll, raising wages and improving access to medicines have reduced the need for fee collection at the facility level. However, two surveys, from 2011 and 2012, found that fee collection has continued, albeit at a lower rate than prior to the introduction of free health care, with roughly 20% of patients reporting payment for treatment that should have been free (Stevenson et al., 2012).

Another interesting feature of the attendance monitoring system is that it built on existing human resource policies and practices rather than reengineering the system. The demand for greater accountability in the health sector is putting pressure on HRMO to improve its performance as the central employment agency for government, and one might speculate that this is helping strengthen *de jure* human resource processes and resolve kinks in the system.

#### But at the expense of cross-sectoral coherence?

However, by responding reactively to an *ad hoc* presidential agenda with a narrow sector focus, the free health care initiative has bypassed other government-

wide reform efforts. Particularly questionable is the impact of the initiative on the integrity of the budget process. The costs associated with the free health care initiative were not included in the original 2010 budget. While donors agreed to finance most of the capital costs associated with the initiative, salary uplifts tripled the health wage bill and donor support covered only about half of this. MoFED was forced to renegotiate its benchmarks with the International Monetary Fund (IMF) to allow for the fiscal expansion this wage bill expansion would require.

Similarly, health worker wages were raised unilaterally at the request of the president with little consideration for the impact on government-wide pay reform. The government has a single salary scale for all civil servants in order to prevent wage competition between agencies, yet in the case of the free health care initiative the government in effect bypassed this by granting salary increases to technical staff (nurses, doctors, lab technicians etc.) whose special qualifications gave them special designations in the pay scale.

Lastly, the attendance monitoring system itself is one of a host of different performance management initiatives currently in train across the government of Sierra Leone. A large World Bank-funded pay and performance project is currently under design with HRMO, which aims to introduce performance contracts and performance reviews for all staff. It remains to be seen whether this new project will build on the processes established in health or introduce a new and parallel system. There is a risk that this plethora of donor-led initiatives to increase the performance drive in government will pull in different directions, sap capacity and weaken the effectiveness of individual efforts.

### 3.3.2 Extent of effective top-down performance discipline or bottom-up accountability mechanisms

In the short term, the attendance monitoring system appears to have strengthened top-down performance discipline in the health sector. Data from the systems suggest absenteeism has decreased since the salary freezes were introduced in January 2011 for staff with

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8 Interviews with staff at three facilities in Bo and Freetown, 17-18 September 2012.

9 Email exchange with Charlie Goldsmith Associates, London, November 2012.

10 Confirmed in multiple interviews with health workers in Sierra Leone, 17-18 September 2012.

more than five days of unauthorised absence. By the end of the year, roughly 661 staff (8% of staff on the payroll) had had their salary withheld for at least one month owing to poor attendance. Data from January to July 2012 show 195 staff (2% of staff on the payroll) sanctioned, which suggests a 50% drop in the share of staff sanctioned for absenteeism, if this trend continues.<sup>9</sup> These salary freezes have brought in savings of roughly \$80,000 in the first year and a half of implementation.

Health clinic in-charges also reported that the system had increased their authority as managers, enabling them to enforce discipline on other performance measures than just attendance.<sup>10</sup> One in-charge reported that he checked the sign-in sheets regularly to ensure staff arrived and left on time.<sup>11</sup> Another disciplinary challenge MoHS faced was that staff transferred to a new location (rotations are carried out frequently) often resisted the move and stayed in their old duty station. The new system monitors staff in their designated duty location, with salaries cut if they do not report at the right facility. While managers and district health teams faced initial resistance from staff when the system was being introduced, they believed the reform was successful because it was introduced in conjunction with significant pay increases, which imposed not only sanctions but also higher rewards. Staff also reported that they thought the new system was fairer and therefore increased morale.<sup>12</sup>

Second-generation reforms are in motion as a result of this improvement in human resource management information. For instance, recognising that staff were spending too much time in training and further study compared with working time, MoHS has placed a temporary ban on in-service training until it completes a training policy. Furthermore, better quality information about staffing levels is helping MoHS in its current effort to improve the distribution of human resources by transferring workers from overstaffed to understaffed facilities.

Furthermore, the monitoring system does incorporate bottom-up accountability measures. The attendance monitoring sheet completed by the in-charge at facility level requires sign-off by a community representative (usually a member of the community health committee). DFID is also funding an initiative to encourage civil society monitoring of health facilities, which remains in an early phase of implementation. This initiative would also encourage greater community involvement in attendance monitoring.

Some critics have questioned the robustness of the system, as it leaves scope for workers and

## Box 1: How the attendance monitoring system strengthens managerial powers

The in-charge in one health clinic in greater Freetown reported that the attendance monitoring system had strengthened his authority as a manager. Because he manages the system, he is now seen to have the power to sanction poorly performing staff. While workers were at first dismissive of the new measures, four staff from the facility have had their salary frozen since the system was introduced, which has proven to the entire staff body that the system has teeth. The monitoring system has also encouraged greater community involvement. The chairman of the community health committee has taken to conducting regular spot-checks to make sure the attendance ledger is accurate. However, the in-charge also reported that enforcing the system had not been easy: in one case he was confronted and threatened by members of staff.

managers to collude. While MoHS conducts regular spot-checks, there does seem to be some evidence of underreporting of absenteeism: currently, about 50 staff a month have their salary withheld for lack of attendance, which appears low in light of the magnitude of the absenteeism problem prior to the introduction of the system. However, the system was not intended to be a perfectly managed central control. MoHS views it as a first step, but recognises that, for it to be fully effective, managers at different levels of the health system need to have the motivation to deliver services. Some such initiatives are in train; HRMO, for instance, is planning the rollout of performance contracts for civil servants, and the World Bank-financed performance-based grants in the health sector are providing facilities with monetary incentives for the amount of work they undertake. Furthermore, DFID is financing a multi-country research programme, Research for Building Pro-poor Health Systems during recovery from conflict (ReBUILD), which is studying staff incentives in Sierra Leone's health sector in greater depth.

11 Interview with in-charge, greater Freetown, 18 September 2012.

12 Ibid.

### 3.3.3 Enabling environment for locally anchored problem solving and collective action

The government of Sierra Leone keenly felt the need for human resource management reforms in the health sector, and this gap was identified through a MoHS-led planning process in the run-up to the launch of free health care (Scharff, 2011). However, while both government and partners recognised the need to strengthen performance incentives for health staff, the solution to this problem was devised by external consultants rather than through a government-driven problem-solving approach. Furthermore, the system could not have been rolled out without the strong support of external advisors. It is too early to tell if the system has sufficient ownership and anchoring to sustain it once external support is withdrawn.

At the local level, moreover, the free health care initiative has increased reliance on a top-down supply of inputs. In the past, health clinics levied fees and used these resources locally for discretionary spending with the tacit approval/acceptance of MoHS. In place of this, salaries have been increased significantly, staff added to the payroll and a new performance-based grant instituted in clinics. However, the performance-based grant has been disbursed irregularly and entails quite strict regulations as to how funds can be used. This may have narrowed the space for local decision making and problem solving, although it is hard to evaluate the counterfactual.

## 3.4 Implementation approach

### 3.4.1 Mechanism

The described intervention combines support for health workers salaries that totalled £13.5 million in the first three years of implementation by DFID and the Global Fund, combined with policy dialogue through the payroll steering committee and a technical assistance component. The technical assistance component was originally funded by DFID for a two-year period, but has since been extended with support from the Global Fund.

### 3.4.2 Origin

The design of the programme grew out of the payroll cleaning exercise (and rapid recruitment) funded by DFID in early 2010, which provided a number of recommendations for keeping the payroll clean as well as monitoring absenteeism.

### 3.4.3 Process features

#### Seizing political momentum for reform

DFID was able to be reactive and seize opportunities to strengthen performance discipline when they arose. In response to strong momentum for health sector reform, backed by the president, DFID mobilised quickly and used an existing technical assistance contract to subcontract the payroll consultants to establish the attendance monitoring system. The government and donors realised it was critical to introduce these new reporting requirements in tandem with wage increases, so that staff recognised that higher remuneration was contingent on performance improvements.

#### Building on existing relationships

The same consulting team that led the 2010 payroll cleaning exercise was brought back to lead the attendance monitoring system rollout, which gave it a strong interest in ensuring project success. This team already had relationships in Sierra Leone developed during the payroll cleaning work, which helped open doors and cement trust rapidly.

#### Wide consultation to ensure buy-in

Although the design of the attendance monitoring system was top-down, the team recognised the importance of consulting and sensitising health workers to the reform, and staff spent considerable time in the districts introducing managers and in-charges to the system. The Human Resources for Health Support Unit in MoHS continuously conducts regular field visits, listens to concerns raised at field level and adjusts the system on the basis of such feedback. The consultancy team also built strong relationships with the central agencies whose participation was critical.

#### Tight feedback loops

One further advantage of the project is that it has tight feedback loops that allow stakeholders to track progress regularly. Every month, MoHS receives reports from all health facilities in the country, which allows it to regularly analyse progress and work with facilities and districts to correct errors as they emerge.

## 3.5 Challenges

While the immediate effects of the intervention are positive, a big concern among stakeholders is its sustainability. At the conceptual level, a significant body of research has questioned the applicability of traditional principal-agent models to developing countries. Criticism has been levelled on two counts. First, an influential body of research argues that 'supply-side' governance reform models that see the central government as the principal and service delivery units as self-interested agents rest on the questionable assumption that the central government is motivated to improve public sector performance. Critics argued that political market imperfections, such as incomplete information, lack of credible commitments and social polarisation, create divergences between the preferences of politicians and those of citizens (Keefer and Khemani, 2003; World Bank, 2004). This led to a rise in popularity for 'demand-side' governance reforms that focus on overcoming the information asymmetry between citizens and state actors (World Bank, 2004). However, more recent research rejects both the supply- and the demand-side principal-agent framework on the grounds that both state and citizens have vested interests in service delivery system dysfunctions (Booth, 2012). It is argued that it is more fruitful to view these dysfunctions as a symptom of collective action challenges that must be overcome through negotiation and bargaining.

In the case of Sierra Leone's health care reform, however, the traditional principal-agent model provides a plausible diagnosis of the government's short-term motivations. Strong political commitment to health care reform from the president and development partners created pressure from the top to improve health worker discipline. However, for this diagnosis to hold, the principal's interests must stay constant. There is good reason to suspect that both the president and donor attention to health worker performance will wane with time as new development initiatives seize the spotlight.

As both government and donor attention shifts to new projects and reforms, the focus on this 'old' attendance monitoring system may slip. Because the system relies on inputs for a large number of actors from facility level and up to MoFED, failure on the part of any actor in the chain to perform their function jeopardises the entire system. A partly functioning system will soon lose its credibility, as

partially enforced performance disciplines are likely to be perceived as unfair. At present, budget support conditions ensure senior officials in government continue to pay attention to the system functionality, but interviewees questioned whether this level of attention could be sustained without external oversight. Already, high-level attention is waning; the role of attending the payroll steering committee, which used to comprise senior government officials, is now more frequently delegated to junior officials.<sup>13</sup>

Furthermore, the grease that keeps the system running (fuel for the vehicles the Freetown payroll office uses to make monitoring trips; stationery and printing; fixes to quirks in the database system etc.) is currently donor funded. A senior government official expressed uncertainty about whether or not MoHS would have the will and ability to continue financing these routine but time-sensitive tasks in the absence of donor funding.<sup>14</sup>

While DFID is committed to continuing to support the health care sector in Sierra Leone and has recently approved a new health project that includes human resource management support, it remains to be seen how long donor support for this particular model is sustained. Donor agencies are frequently under pressure to deliver new programmes and demonstrate they have moved on from basic to more advanced reforms. High staff turnover among donor agencies often means ownership for a particular reform dwindles with time.

This case study also brings to light challenges in balancing intra-sector coherence with cross-sector coherence. While the reform made a great deal of sense within the health sector and successfully rode the political momentum for health sector reform (particularly the pressure to raise health worker wages) to introduce greater staff accountability, it pre-empted a number of government-wide performance management reforms. The current system requires officials in the Accountant-general's Office and HRMO to give special attention to the health sector payroll that may be difficult to justify in the long-term. It remains to be seen if the health sector's experimentation with attendance monitoring will serve as a pilot initiative that will be adopted government wide and thus more firmly institutionalised, or if subsequent performance management initiatives will supersede it.

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<sup>13</sup> Interview with senior government official, Freetown, 12 September 2012.

<sup>14</sup> Ibid.

# 4

# Lessons and conclusions

Donor support to the introduction of a health worker attendance monitoring system in Sierra Leone has had positive short-term effects on staff discipline. Absenteeism appears to have fallen since the introduction of the reform and, perhaps most importantly, managers at facility, district and national level reported that the system had given them more authority as managers, because of increased power to discipline misconduct, and more management information on which to base decisions.

However, the intervention rests on a traditional principal-agent theory of change that assumes the central government is motivated to improve civil servant performance. While this may be true in the short-term, it is questionable whether this performance pressure from the top will be sustained once other development objectives supersede free health care.

The case study nonetheless provides some useful lessons for development partners to consider when designing aid interventions aimed at improving governance.

## **Allow service delivery bottlenecks to drive governance improvements**

The strong political momentum behind the free health care initiative gave stakeholders a strong incentive to improve payroll management. A standalone performance management reform is unlikely to receive the same attention and commitment as when a governance reform becomes a necessary condition for programmatic success. Furthermore, a delivery-focused approach helps focus attention on the outcomes the system can deliver, rather than the system itself.

## **Analyse any trade-offs between within-sector coherence and cross-sector coherence**

While the political imperative to deliver free health care helped government and partners to overcome many of the common bottlenecks to public sector reform, it did so by bypassing government-wide reform processes (e.g. pay reform). This approach may have been justified in the Sierra Leone context, but a project's possible impact on cross-sectoral coherence should be acknowledged and considered during the design phase.

## **Use sector budget support to enforce rather than introduce new systems**

In this case, donor conditionality was used to enforce a particular process, rather than introduce a policy reform (e.g. design of a new law or policy document). By using donor conditionality to 'test the plumbing' rather than reengineer it, pressure will mount to resolve kinks and bottlenecks in the system. Further research is needed to determine whether or not this approach offers advantages and is possibly a more sustainable path to reform in contexts where written laws and policies do not necessarily result in action.

## **Welcome flexibility and responsiveness**

The scope and nature of DFID's support to health sector human resource management have evolved over time. The initial report of recommendations from the consultant who carried out the payroll cleaning led to the design of a technical assistance programme, which was rapidly tacked onto an existing technical assistance programme in MoHS. This technical assistance component has been extended twice and is currently financed by the Global Fund. This flexibility in response to a fluid and unpredictable government-led reform process should be encouraged rather than regarded a sign of poor planning.

- Booth, D. (2012) 'Development as a Collective Action Problem: Addressing the Real Challenges of African Governance'. Synthesis Report. London: ODI, African Power and Politics Programme.
- Brown, Taylor, Fanthorpe, R., Gardener, J., Gberie, L., and Sesay, M. G. (2006) *Sierra Leone: Drivers of Change*, the IDL group, funded by DFID
- Charlie Goldsmith Associates (2012) 'Improving Pay and Attendance amongst Government Health Workers in Sierra Leone'. Health Governance and Finance Panel Sierra Leone–UK Health Partners Conference.
- Collier, P. (2007) 'Accountability in the Provision of Social Services: A Framework for African Research'. Oxford: CSAE.
- Donnelly, J. (2011) 'How Did Sierra Leone Provide Free Health Care?' *The Lancet* 377(9775): 1393-1396.
- Ensor, T., Leivens, T. and Naylor, M. (2008) 'Review of Financing of health in Sierra Leone and the Development of Policy Options'. Oxford: Oxford Policy Management.
- MoHS (Ministry of Health and Sanitation) (2011) *Health Information Bulletin* 2(3), FHC (Apr 2010—Mar 2011) Edition.
- Government of Sierra Leone, National Aids Secretariat and Government of the United Kingdom (2011) Draft Memorandum of Understanding concerning respective responsibilities in a joint effort to pay salaries of health workers in Sierra Leone, unpublished.
- IGC (International Growth Centre) (2011) 'Transformation and Development in Sierra Leone'. Background Note on Health Infrastructure, Policies and Programmes, Conference on Transformation and Development: Social Service Delivery.
- Keefer, P. and Khemani, S. (2003) 'Democracy, Public Expenditures and the Poor'. Washington, DC: World Bank, Development Research Group.
- Koroma, E.B. (2012) 'The Free Health Care Initiative is Making a Difference in Sierra Leone'. *Huffpost Impact United Kingdom*, 4 May, [http://www.huffingtonpost.co.uk/ernest-bai-koroma/sierra-leone-fhci-the-free-health-care-init\\_b\\_1473835.html](http://www.huffingtonpost.co.uk/ernest-bai-koroma/sierra-leone-fhci-the-free-health-care-init_b_1473835.html)
- Pritchett, L. (2012) 'Promoting Capability for Policy Implementation: Why and How'. OECD Global Forum on Development, Paris, 28-29 February.
- Robinson, J. (2008), *Governance and Political Economy Constraints to World Bank CAS Priorities in Sierra Leone*, Washington DC, World Bank
- Scharff, M. (2012) 'A Promise Kept: How Sierra Leone's President Introduced Free Health Care in One of the Poorest Nations on Earth, 2009-2010'. *Innovations for Successful Societies*. Princeton, NJ: Princeton University.
- Srivastava, V. and Larizza, M. (2012) 'Working with the Grain for Reforming the Public Service: A Live Example from Sierra Leone'. Policy Research Working Paper 6152. Washington, DC: World Bank.
- Stevenson, D., Kinyeki, C. and Wheeler, M. (2012) 'Evaluation of DFID Support to Healthcare Workers Salaries in Sierra Leone'. London: DFID, Human Development Resource Centre.
- Wild, L., Chambers, V., King, M., Harris, D. (2012) *Common constraints and incentive problems in service delivery*, Research Paper, London: ODI
- World Bank (2004) *World Development Report 2004: Making Services Work for the Poor*. Washington, DC: World Bank.
- World Bank (2010a) 'Sierra Leone: Public Expenditure Review'. Washington, DC: World Bank.
- World Bank (2010b) 'World Development Indicators 2010'. Washington, DC: World Bank.
- Wyrod, C. (2008) 'Sierra Leone: A Vote for Better Governance', *Journal of Democracy*, 19, 70-83.

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# Appendix 1: Interviewees

Prince E.O. Cole	Director, Human Resources, MoHS
Ernest S. A. Surrur	Director General, Human Resource Management Office
Elizabeth Lemor	Payroll Office, MoHS
Mabel Carew	Chief Nursing Officer, MoHS
Sorie Kamara	Financial Management Advisor, MoHS
Ernest S.A. Surrur	Director-general, HRMO
M.R. Koroma	Deputy Director-general, HRMO
Remielekue Ibrahim Cole	Data Entry Operator, HRMO
Matthew Dingie	Budget Director, MoFED
A.B. Conteh	Accountant-general's Office
Dr. Foday Sisay	Hospital Superintendent, Bo Hospital
Henrietta Caulker	In-charge, Under-5 Clinic, Bo
Winfred Ngeba	Maternal-Child Health Aide, Under-5 Clinic, Bo
Princess Bangura	Waterloo Health Clinic
Julius Mattia	Waterloo Health Clinic
G.B. Timbo	Wellington Health Clinic
Charlie Goldsmith	Charlie Goldsmith Associates
Erin Chu	Charlie Goldsmith Associates
Howard Tytherleigh	Charlie Goldsmith Associates
Donald S. Conteh	Lead Programme Officer, Health System Strengthening, Global Fund
<b>Members of the Direct Health Management Teams of Bo and Western Areas</b>	







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