Project Completion Report

Review Date:	**June 2015**

Title: Increasing the provision of essential health care services through support for health workers in Sierra Leone		
Programme Code: 201853	**Start Date: July 2010**	**End Date: February 2015**

Summary of Programme Performance

Year	**2011**	**2012**	**2013**	**2014**	**2015**
Programme Score	**61.250**	**A**	**A**	**B**	**A**
Risk Rating	**High**	**High**	**High**	**High**	**High**

Financial Position

Original Programme Value	**£12,000,000**
Extensions/ amendments	None
Log-frame revisions (with dates)	• 2010 (original logframe) • July 2011 – first revision which set milestones against the agreed indicators until 2013 • 2013 – 2015 - milestones set by the Payroll Steering Committee
Total programme spend	**£10,031,161.09**

List of Acronyms

ACC	Anti – Corruption Commission
AGD	Accountant General Department
AR	Annual Review
BPEHS	Basic Package of Essential Health Services
CHA	Community Health Assistant
CHAI	Clinton Health Access Initiative
CHO	Community Health Officer
CMO	Chief Medical Officer
CSO	Civil Society Organisations
DFID	Department for International Development
DHS	Demographic and Health Survey
E4A	Evidence for Action
EVD	Ebola Virus Disease
FHCI	Free Health Care Initiative
GFATM	Global Fund for HIV/AID, Tuberculosis and Malaria
GoSL	Government of Sierra Leone
HFAC	Health For All Coalition
HR	Human Resources
HRH	Human Resources for Health
HRMIS	Human Resources Management Information System
HRMO	Human Resources Management Office

HSC	Health Service Commission
IMF	International Monetary Fund
IRMNH	Improving Reproductive, Maternal and New-born Health project
LFA	Local Funding Agency
MCH Aide	Maternal and Child Health Aide
MDAs	Ministries, Departments and Agencies
MICS	Multiple Indicator Cluster Surveys
MOFED	Ministry of Finance and Economic Development
MOHS	Ministry of Health and Sanitation
MoU	Memorandum of Understanding
PCR	Project Completion Report
PHU	Primary Health Care Unit
PSC	Payroll Steering Committee
RAA	Remote Area Allowance
ReBUILD	Research for Building Pro-poor Health Systems during recovery from conflict
RMCH	Reproductive Maternal Child Health
TA	Technical Assistance
VfM	Value for Money
VSO	Voluntary Services Overseas
WHO	World Health Organisation

Programme summary

DFID committed £12,000,000 to uplift frontline health workers' salaries in Sierra Leone from 2010 to 2015. The programme was designed to support the implementation of the Free Healthcare Initiative (FHCI), launched in April 2010, which made health services free for pregnant women, children under five years of age and nursing mothers. Increasing the availability of frontline health workers to deliver services, by uplifting their salaries and introducing a sanction framework was hoped to discourage the application of user fees for services to mothers and children and support the aims of the FHCI. It was estimated that over the implementation period 1.1 million pregnant women, lactating mothers and 5 million children under the age of five could benefit, with a total of 141,000 lives saved.

DFID funding was allocated as budget support to the Government of Sierra Leone (GoSL), with disbursements released based on progress made against agreed milestones that were monitored by a joint donor Government Payroll Steering Committee (PSC). Over the lifetime of the project underperformance against some of the milestones led to £600,000 of the funding not being disbursed.

The project was delivered through three outputs, aimed at increasing the uptake of health care by the most vulnerable. These included the efficient management of the payroll, enhanced capacity of the MOHS to manage the attendance and deployment of human resources for health (HRH), and effective community oversight of the FHCI. DFID, through its Reproductive Maternal and Child Health (RMCH) project provided complementary support for technical assistance to develop a payroll and HR management system; support community monitoring of the FHCI; and fund Voluntary Service Overseas (VSO) to provide additional medical personnel. This complementary support ended in 2012 after which the Global Fund for HIV/AIDS, TB and Malaria (GFATM) took over the technical assistance costs until December 2012. The GFATM also started paying remote area allowances (RAA) to encourage the retention of health workers in rural areas. This was paid to an account in the MOHS and was separate but complementary to DFID's support to the salary uplift.

Overall, the project has scored an A as its met expectations. It has contributed to an increase in the uptake and utilisation of health care service. The salary uplift has helped to attract and retain health workers in the public health sector. Absenteeism and moonlighting have been reduced, and more health workers are motivated to come to work on time, remain in the workplace and provide services, despite increasingly heavy workloads as a result of the removal of user fees. The salary uplift has also attracted health workers back from the private sector.

Payroll cleaning and maintenance resulted in the removal of 'ghost workers' from the payroll and led to a total estimated saving of $408,200. A further $290,800 was saved after the introduction of the Conduct

and Sanction Framework between March 2010 and May 2012. The attendance monitoring system and sanctions for absenteeism are well understood and have been implemented at facility and district levels.

The holding of PSC committee meetings and the frequency of monitoring visits to the districts decreased in the last year due to travel restrictions that were put in place because of the Ebola outbreak. This has meant that there is limited data to judge performance against the 2015 milestones. However key informants have reported that the support provided to salaries through this project, and the availability of motivated frontline workers contributed to the resilience of the health workforce during the Ebola outbreak and enhanced the GoSL's response to it.

Recommendations

For the GoSL/MOHS:

1. Carefully consider the affordability and sustainability of absorbing EVD workers onto the Government payroll. Ensure the recruitment and deployment of Ebola workers address the skills and needs gap in the health sector.
2. Regularly clean and update the payroll database, especially in light of the EVD outbreak. Fill the GFATM funded Technical Assistance position as a matter of urgency.
3. Develop a fully functional national Human Resources Management Information System (HRMIS) for the health workforce. Support districts to keep records and regularly update the central HRMIS database.
4. Modify the payroll software to enable the generation of consolidated data on health worker stock, distribution and characteristics at facility, district and central levels.
5. Make the eligibility criteria for receiving incentive payments/allowances transparent and integrate all allowances onto the payroll system. Explore the use of mobile phone money transfers to ensure that incentives reach health workers in a timely manner.
6. Focus future support on strengthening district and health facility management of human resources in support of the decentralisation policy and to build resilience of the health system. Establish HRH support units at the district level and allow them to appoint, deploy, and discipline health workers. Make districts responsible for reporting against HRH indicators to the PSC to strengthen accountability.
7. Work with communities and youth to monitor and verify staff attendance, report on absenteeism and illegal fee-charging.Explore the use of mobile technology applications for realtime reporting.
8. Revise, finalise and approve the Scheme of Service to ensure that all health workers' job designations match grades.
9. Further strengthen the partnership between MOHS, AGD and HRMO and establish effective mechanisms to improve communication and coordination between relevant directorates (HRH, Financial Resources, and Health Systems Policy, Planning and Information).

For DFID and other development partners:

1. Consider continued support to health workers salaries and human resource management system at the central and district level to safeguard the gains made through this project. Consider increasing the salaries of key administrative staff in the MOHS to improve motivation and performance.
2. If TA is provided ensure it is coordinated with other partners and sufficiently resourced to avoid fragmentation. Clearly defined reporting structures so that the TA is held accountable for delivering key milestones.
3. Support the HRH Directorate with financial resources (including communication), logistics and manpower to carry out monitoring and verification exercises effectively, using the HRH monitoring tool, and to manipulate the data to generate reports.
4. Support district and hospital management to monitor and report on HR and use the data for the management of their workforce.
5. Strengthen the link between community, the service providers and central decision making bodies to ensure effective community engagement. Explore how it can build on the community engagement generated though the HFAC, and during the Ebola response to improve the accountability of providers and Government for the delivery of basic services.

Introduction and Context (1 page)

DevTracker Link to Project Memorandum:	**2660334**
DevTracker Link to Log frame:	**3619572**

Outline of programme and what it has achieved

The *'Increasing the provision of essential health care services through support of health workers in Sierra Leone'* project was initiated to support the introduction of the 'Free Healthcare Initiative' (FHCI) by the Government of Sierra Leone (GoSL), to improve Sierra Leone's maternal and child mortality rates. At the time health workers in Sierra Leone were financially demotivated; a medical doctor in Sierra Leone earned $150 per month and a nurse $50. Health workers charged for their services to supplement their meagre incomes.

The FHCI was launched in April 2010 to provide free health care services at the point of delivery, for pregnant women, lactating mothers and children under the age of five years, by removing user fees for them, thereby increase their access to key healthcare services. DFID provided the financing to enable the GoSL to increase healthcare workers' salaries to an acceptable level that would motivate health workers to deal with increased workloads, and discourage them from charging the FHCI target groups for services. This supported the implementation of the FHCI and was expected to increasing the uptake of healthcare by the most vulnerable and contribute to improved maternal and child health outcomes. In order to protect the investment in the salary uplift, the GoSL developed a Conduct and Sanctions Framework in 2010. This introduced an official HR management mechanism to reduce the high rate of staff absence, and sanction poor health worker performance to increase the efficient and effective implementation of the FHCI.

The 2010 project memorandum estimated that over the implementation period 1.1 million pregnant women, lactating mothers and 5 million children under the age of five could benefit with a total of 141,000 lives saved. From a total commitment of £12 million, DFID disbursed £10.03m in budget support to the GoSL through the MOFED to support the salary uplift of health workers. The release of DFID disbursements were subject to performance against a set of agreed indicators and milestones benchmarks. The GFATM complemented DFID's support by providing $16.9m (2013-2015) to the MOHS for a remote area allowance scheme for health workers posted to rural areas.

The five year programme commenced in June 2010, and initially (from 2010 to 2011) delivered through four outputs which aimed to:

i. Sustain the removal of user fees through a regularly paid salary uplift
ii. Keep the whole health payroll clean and ensure it is managed well by Government.
iii. Generate reliable and accurate information and data enabling Government to monitor staff attendance and manage personnel deployment, and
iv. Support the implementation and where necessary enforcement of the no user fee policy.

The original log frame and outputs were revised in July 2011 in response to the 2011 DFID annual review recommendations. These focused less on minimising charging of user fees, a goal the original logframe had set out to achieve, and more on payroll management and attendance monitoring. The revised goal of the programme was: *'To support the successful implementation of the FHCI in order to secure health outcomes'*. The revised outputs were as follows:

i. Health Payroll managed effectively
ii. Enhanced capacity of MOHS to manage human resources for health with respect to attendance and deployment
iii. Effective community oversight of FHCI by civil society

Some of the activities related to these outputs were not directly funded by this project and included work being supported by a pre-existing DFID RMCH project that ran until March 2012. The revised log frame only set out milestones until 2013. It was agreed that the Payroll Steering Committee (PSC) could set subsequent milestones to enable them to respond to emerging challenges and realities on the ground. Unfortunately, the milestone changes and the reasons for the changes were not well documented.

The PSC was tasked with overall responsibility for the coordination and monitoring of the payment of health workers' salaries under this project. In particular it was responsible for reviewing progress against the agreed milestones. Satisfactory achievement of the milestone would trigger the release of the disbursements from DFID. After approval at the PSC stage, the MOHS would communicate with MOFED, which then made a formal request for the funds to DFID. On four occasions under-performance against the milestones resulted in financial penalties being applied and a reduction in the amount of funds disbursed. Over the lifetime of the project a total of £600,000 was not disbursed due to underperformance. The reasons for this are described in Section D but mostly concerned the timeliness of submitting audit reports.

In order to support the achievement of the outputs and fill an immediate need DFID also allocated £425,749 to the Voluntary Service Overseas (VSO), which provided medical personnel to support the health workforce from 2010/11 to 2011/12. In addition, between July 2010 until March 2012, DFID Sierra Leone's Reproductive and Child Health Project (Aries number 200344) provided complementary support to HRH. This included £705,837 to Options Consultancy to provide TA to support the development of a payroll and human resource management system; and £380,000 to the Health for All Coalition (HFAC), a civil society organisation (CSO) to promote community engagement in the implementation and monitoring of the FHCI.

After the closure of DFID's RMCH project in March 2012 the GFATM took over the funding of the TA until December 2012, but it was not continued after that. Plans to contract further TA by the GFATM has been delayed, as a result of the 2014 EVD outbreak , which has had some impact on the effectiveness of this component of the programme.

Overall, the programme contributed to an increase in service utilisation (see section B) which can be attributed to the salary uplift for health workers. This is also in line with evidence based findings on health worker incentives in Sierra Leone reported by the DFID funded ReBUILD research project. The salary uplift contributed to attracting and retaining health workers in the public health sector. The financial rewards enhanced health worker motivation to undertake the heavy workloads as a result of increased take up and utilisation of services as a result of the removal of user fees.[1]

Key informants interviewed as part of the ReBuild assessment, reported that the salary uplift attracted health workers from the private sector back into the public sector, with the most senior staff, such as specialist doctors on Grade 12 receiving an increase of more than 700%. However the increase for the lower grade staff was less significant, creating a wide differential between doctors and other cadres. Key informants interviewed for this review also implied that the occurrence of health workers 'moonlighting' which had been a common phenomenon in Sierra Leone had reduced. This reduction can be attributed in part to the Conduct and Staff Sanction attendance monitoring tool introduced to reduced unauthorised absenteeism in the workplace. Thus this programme did help ensure that health workers were in the health facilities and not working elsewhere.

In addition, the payroll cleaning exercise removed approximately a 1000[2] ghost workers from the payroll (representing an estimated saving of $408,200 between March 2010 and May 2012), thereby ensuring that the salary uplift was going to health workers that were in their workplaces offering services to the target group. The attendance monitoring system that was introduced also helped to improve the availability of frontline health workers and reduce unauthorised absenteeism in the health facilities, which may have contributed to some extent to the resilience of the health workforce and its ability to respond to the EVD outbreak.

[1] Wurie. H. and Witter, S. (2014) Serving through and after conflict: life histories of health workers in Sierra Leone. Report for ReBUILD (available online: http://rebuildconsortium.com/publications/documents/IDIreportSLfinal230614.pdf)

[2] The ghost workers included approximately 850 workers who had retired but not removed from the payroll, plus health workers that had died or had no defined work station. References: Booz and Company (May 2010) Government of Sierra Leone Ministry of Health: Payroll Cleansing in support of President's Free Health Care Initiative: Post-Assignment Summary and Donnelly J (2011) Specia Report: How did Sierra Leone provide free health care? The Lancet Volume 377, No. 9775, p1393–1396.

Sierra Leone has experienced a devastating Ebola outbreak over the last year that has resulted in over 12,000 cases and nearly 4000 deaths. Health services were severely disrupted with staff and resources being diverted into fighting the epidemic and routine services being unavailable or unutilised due to communities' fear of catching EVD from health facilities. Preliminary findings from the UNICEF Health Facility Assessment[3] survey indicate that most Primary Health Units (PHUs) are now open and functioning again and, using Maternal and Child Health (MCH) Aides as a proxy, there was limited attrition of health personnel across all districts. However it was reported that a total of 215 personnel "abandoned" posts, of which 15% were MCH aides, 10% nurses and 2% community health officers (CHO)/community health assistants (CHA) and 73% were from among the 'other personnel' categories. Tragically 221 health workers reportedly died from EVD.

The EVD outbreak has affected some of the project's activities and achievements. A decrease in service utilisation has reduced coverage of many of the lifesaving preventative health interventions that are indicators of the project's success. In addition, information on achievements against the set milestones for 2014-2015 was not available due to lack of Payroll Steering Committee meetings and monitoring. As this was outside of the control of the project is was decided not to score the project down because of it. Therefore the project has scored an A, as it has met expectations.

[3] Sierra Leone Health Facility Survey 2015 : Assessing the Impact of the EVD Outbreak on Sierra Leone's Health System, UNICEF Sierra Leone

B: PERFORMANCE AND CONCLUSIONS (1-2 pages)

The project under review also complements other DFID funded programmes that are working towards improving maternal and child health outcomes, generating evidence on how to attract and retain a well distributed motivated heath workforce and improving the quality and access to health services. They are:

- Improving Reproductive, Maternal and New-born health' (IRMNH) programme;
- Evidence for Action for Maternal and Child Health (E4A) programme;
- Research for Building Pro-poor Health Systems during recovery from conflict (ReBUILD) programme; and
- Improving quality and access to the Basic Package of Essential Healthcare Services' (BPEHS) programmes.

Overall Outcome Assessment

The expected impact is to 'increase the uptake of health care by the most vulnerable' in supporting the successful implementation of the FHCI and improve health outcomes. An external evaluation report in 2012 concluded that *'it can be said with confidence that the salary uplift was critical to the success of the FHCI thus far*[4]*.* The overall expected outcome of this programme is to increase the uptake of health care by the most vulnerable, i.e. the FHCI target group. The final outcomes achieved and progress against the milestones are shown in the table below.

Indicator		Milestone upon completion	Achieved (from 2014 AR)	2015
Percentage of deliveries attended by a skilled birth attendant (doctor, nurse/midwives/Maternal and Child Health Aide)	42.4% (DHS 2008)	60%	**60%** **A**	**Not yet available**
Percentage of women receiving IPT (Intermittent Preventive Treatment for malaria prevention) 2+ doses) during pregnancy	10% (DHS 2008)	60%	**73%** **A+**	**Not yet available**
Percentage of children under 5 with a fever in the last two weeks treated with anti-malarial drugs	30% (DHS 2008)	47%	**48%** **A**	**Not yet available**
Percentage of free healthcare patients reporting paying fees for treatment (of those interviewed by CSO monitors)	Pre FHCI launch – 100% charged	20% or less	**12%** **A+**	**Not available**
Percentage of health workers absent without authorization	Not known	10%	**2.6%** **A++**	**2%** *(from analysis of routine HR data from the HRH support unit for April 2015)* **A++**

Data on achievement for the outcome indicators is not available for 2015. This is because the main sources of data to assess progress for the outcome indicators were to be the Demographic and Health Survey (DHS) 2013 and Multiple Indicator Cluster Surveys (MICS). These were meant to have been conducted in 2014 and 2015 respectively. However, due to the EVD outbreak the DHS could not be carried out and the MICS could not be planned for 2015.

The table above shows an improvement in all the indicators assessed in 2014 and demonstrates that the programme was exceeding its expectations and on track to achieve its outcome pre Ebola. The percentage of skilled birth attended deliveries met its target and the percentage of women receiving IPT during

[4] Stevenson, D., Kinyeki, C., & Wheeler, M. 2012, Evaluation of DFID Support to Healthcare Workers Salaries in Sierra Leone, DfID Human Development Resource Centre, London

pregnancy (service delivery outcomes) substantially exceeded its target. However the Ebola outbreak has significantly disrupted health services and utilisation. The May 2015 Health Facility Assessment reported that in the last year the proportion of children seeking treatment for malaria declined by 31%, antenatal visits (where IPT would be provided) declined by 14% and deliveries decreased by 7%. It is estimated that the decrease in coverage of lifesaving preventative health interventions may cause an additional 4000 non Ebola child deaths in 2015 [5].

The percentage of FHCI service users reporting having to pay for health services and drugs has also improved considerably compared to the pre FHCI situation. This can also be attributed in part to concerted efforts from DFID's IMRNH and BPEHS programmes which ensured that the incidence of drug stock outs in the health facilities was minimised and that health workers were equipped to meet the demand of the increased utilisation post FHCI. However, the key informant interviews conducted as part of this review did revealed that the target groups are still being asked to pay for services in some incidences. The extent of this need to be elucidated further elsewhere, as support for this indicator was only provided up to March 2012 by DFID.

The attendance monitoring tool also proved to be effective. The percentage of unauthorised absenteeism was calculated as 2% based on routine analysis of unauthorised absenteeism (calculated as 'staff with one or more days of unauthorised absence /number of staff on payroll) data collected from the HRH support unit. This falls below the milestone of 10% upon programme completion, highlighting further the positive impact the project has made. Thus, it can be concluded that despite the disruption of the last year, the project has achieved its stated outcome and made a valuable contribution to DFID's support to maternal and child health outcomes in Sierra Leone.

Output Score and Description

The project was assessed as 61.250 in 2011, A (outputs met expectations) in both 2012 and 2013 and B (outputs moderately did not meet expectations) in 2014. In 2012 good progress was made with regards to payroll integrity and attendance management but the issue of sustainability was a concern. At that time measures were also being put in place to help build the institutional capacity of Health For All Coalition (HFAC) to engage effectively in monitoring the FHCI. Progress made in 2013 was encouraging again with regard to payroll integrity and attendance management, and substantial progress was made in the operationalisation of the monitoring and reporting framework for HFAC. There was a need identified for technical assistance to support HFAC improve its institutional capacity, which was provided on a short term basis.

In 2014 moderate progress was demonstrated, with good performance reported on payroll management and attendance monitoring, but challenges reported with regards to the timely processing of requests for the amendment of the payroll. HFAC made good progress in monitoring and reporting on the availability of FHCI commodities and maternal deaths, but less on monitoring staff attendance and the charging of user fees by health workers for FHCI services. HFAC reported that there was insufficient funding to actively monitor staff attendance which involved more frequent trips to health facilities than checking the quarterly delivery of drugs. Subsequently, the partnership between HFAC and the Anti-Corruption Commission (ACC) focused more on monitoring the misappropriation of FHCI commodities and less on health worker misconduct.

The 2014 Annual Review gave an overall score of B, as programme outputs did not moderately meet expectations, particularly for outputs 2 and 3, as a number of issues were not addressed. These related to the fragmented approach to institutionalising capacity building initiatives as a result of a lack of continuity of efforts and the high turnover of staff at the MOHS. It recommended the need to improve the coordination of TA needed to support the sustainability of the programme.

Impact of EVD

The 2014 EVD had an impact on the project across the board. Utilisation of maternal and child health services dropped by 14% for antenatal classes (ANC), 17% (Penta3 vaccination) and skilled birth deliveries by 7% [comparing the period from Oct – Jan 2014/15 (Ebola period) versus Oct – Jan 2013/14 (non-Ebola period)] as reported in the 2015 Health Facility Assessment Report. The number of children

[5] Sierra Leone Health Facility Survey 2015 : Assessing the Impact of the EVD Outbreak on Sierra Leone's Health System, UNICEF Sierra Leone

treated for malaria declined by 31%, which is equivalent to about 27,200 children not being treated for malaria every month. This drop was observed across all districts irrespective of the intensity and duration of the EVD outbreak[6]. Many staff either abandoned their post, due to fear, or were reassigned to work in the Ebola Treatment Centres. The energies, resources and capacity of all those working in health, including development partners, in Sierra Leone were diverted to fighting the epidemic. A number of health workers also died due to contracting the virus. From October 2014 to March 2015, the health facility assessment reported that 124 health personnel had died from EVD (7 CHO/CHA, 19 state registered nurses and state enrolled community health nurses, 27 MCH Aides and 71 other personnel). Thus in the post EVD recovery phase, there is a need to conduct another workforce audit and a payroll cleansing exercise and to support the revitalisation of the payroll management and attendance monitoring system.

The EVD outbreak also affected DFID who led on the international response. There was a high turnover of DFID staff in country, with health advisors staying for a maximum of three months. Thus the administrative supervision of the project from DFID's side was affected. The restrictions in travelling between districts affected monitoring and supervision visits. MOHS was also affected as were the gains made in improving HR management. The EVD outbreak was a shock to the health system as a whole and unprecedented in its scale. However it could be argued that the health workforce was in a better position to respond in terms of the availability attributed in part to the salary uplift and the additional workers recruited and motivated.

Lessons and how these have been shared

The FHCI brought about significant HRH reform in Sierra Leone. The first wave of reforms and the introduction of the Conduct and Sanctions Framework resulted in substantial numbers of ghost workers being eliminated from the payroll which led to monetary savings that was then used to employ additional health personnel. The recruitment and deployment that followed filled many gaps in staffing, particularly at the district level, where the retention of health workers in rural settings was an ongoing challenge.

Some health workers have to work as volunteers for varying lengths of time after qualification, before being absorbed on to the Government payroll. Therefore absorbing health workers is an ongoing challenge, as seen with the volunteer (qualified) health personnel that were used during the EVD response. The wage bill implications of further health workforce expansion must be carefully considered. While the salary uplift contributed to better motivation and retention and unauthorised absenteeism has decreased due to the sanctions put in place, the health system in Sierra Leone is still fragile and unresponsive as exposed by the EVD outbreak and still faces significant challenges, both in HRH and more widely.

Evidence based findings from the ReBUILD project shows that the health workforce is in general mal-distributed, with rural hard to reach areas where the need is greatest at a disadvantage. For example, data from the MOHS's HRH Directorate suggests that the staff to population density for doctors in the Western Area (where the capital city Freetown is based) was 0.07 per 1,000 of the population in 2005 and 0.12 per 1000 of the population in 2011. On the other hand in Koinadugu, a rural and difficult to reach area, the density for doctors was 0.03 per 1000 of the population in 2005 and had only increased to 0.05 per 1000 in 2011. The pattern is similar for nurses and other cadres as well.[7] Thus there is a need to develop attractive retention strategies for health workers, which includes both financial and non-financial incentives (based on the cost of living), to ensure the health workforce remains in place, motivated and responsive.

Pre-EVD the levels of service utilisation were improving, but experienced a decline during the EVD outbreak. In the post EVD recovery phase, efforts should be made to ensure that payroll cleaning and attendance monitoring continues to be supported. The MOHS is planning to conduct a workforce audit and payroll cleansing exercise under the Recovery Period (May – December 2015). This should identify health workers who either died or left service due to EVD and those who left. This evidence will then be used to formulate a national recruitment and redeployment plan for the health workforce.

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[6] Sierra Leone Health Facility Survey 2015 : Assessing the Impact of the EVD Outbreak on Sierra Leone's Health System, UNICEF Sierra Leone

[7] Wurie, H., Samai, M. and Witter, S. (2014) Staffing the public health sector in Sierra Leone, 2005-11: findings from routine data analysis. Report from ReBUILD (available online: http://rebuildconsortium.com/publications/documents/Project2Secondarydatareportfinal071114.pdf)

Coordination between Ministry departments and agencies was supported and promoted by this project but needs to be strengthened further. Better coordination and harmonisation of technical assistance is also needed to ensure that the support provided is not fragmented and has the intended impact. Efforts should also be made to ensure that the capacity built is retained and information and HR management systems improvements are institutionalised.

C: DETAILED OUTPUT SCORING (1 page per output)

A final evaluation of this project was not conducted as originally planned in the project memorandum. Therefore consolidated and synthesised data for 2014-2105 was not available and there is a lack of in-depth analysis on the recruitment, retention and absenteeism of health workers. In addition, there was only limited evidence available on how the payroll has been managed from July 2014 until the end of the project in February 2015. As well as revisions to the outputs in 2011, indicators were also reviewed and a new indicator 'Percentage of staff reported on study leave with authorisation from HRMO' was added by the PSC in 2014, to be measured in 2015. The wording of the other indicators was also changed slightly by the PSC but their meanings remained similar to that in the July 2011 logframe.

In addition, evidence on achievements against the 2014-2015 milestones was not available during the review process due to lack of documentation on the deliverables and outcomes of Payroll Steering Committee meetings. It can be assumed that milestones were met for both outputs 1 and 2 as it triggered disbursement of funds.

Output Title	**Health Payroll Managed Effectively**		
Output number per LF	1	**Output Score**	***A***
Risk:	*High*	Impact weighting (%):	35%
Risk revised since last AR?	*Y*	Impact weighting % revised since last AR?	*N*

Indicator(s)	**Baseline (2010)**	**2014 data value and score**	**2015**		
			Planned	**Achieved**	**Grade**
Percentage of staff with a substantial job designation on the payroll	53%	98.4% A+	95%	**n/a**	**n/a**
Percentage of staff with correct workstation listed on the payroll	32%	90.3% A+	95%	**n/a**	**n/a**
Percentage of staff with a job designation that matches their pay grade	Approx. 53%	95.6% A	95%	**n/a**	**n/a**
Percentage of staff reported on study leave with authorisation from HRMO (new indicator added by the PSC in 2014)	**Not known**	**n/a**	**50%**	**n/a**	**n/a**

Key Points

Data values of the 2015 performance of this output are not available as reporting was disrupted by the Ebola response. However progress against the targets in 2014 mostly exceeded expectations and are unlikely to have reversed in the last year. Based on this and the analysis below the output is judged to have met expectations and scored an A.

Milestones against the indicators for this output were set in the revised logframe of 2011 up until 2013. The Payroll Steering Committee revised the performance milestones from 2013 to 2015, which were reflective of the challenges faced on the ground. This included the revision of the target for the indicator

'Staff with a defined workstation who are on the payroll' from 98% to 85% to be reflective of the introduction of GFATM's Remote Area Allowance (RAA) incentive scheme, which was designed to attract and retain health workers in rural postings. The need to address the issue of unauthorised study leave was a recommendation made in the 2012 Annual Review.

In general over the project's lifespan, performance exceeded expectations with all targets met or exceeded. Tremendous progress was made in the percentage of health workers with official job designation, with 98.4% achieved in 2014 compared to 53% at baseline. The salary uplift was introduced along with a recruitment drive at the district level to meet increased demand, which resulted in a general upward trend (see figure 1 below) in the size of the health workforce and an increase in the number of health workers with a defined workstation at the district level. The RAA scheme supported by the GFATM and managed through the MOHS experienced implementation challenges with delays in payments to health workers[8] .

Motivating health workers with financial and non-financial incentives is an ongoing challenge for Sierra Leone as reported in the ReBUILD project reports. The non-receipt of regular RAA incentives demotivates rural health workers, who are also faced with additional challenges in their remote locations. These included the regional disparities in training opportunities, with urban health workers getting greater access to workshops and courses; long working hours due to low staff numbers (because of difficulties recruiting/retaining health workers in rural locations) and the lack of accommodation and utilities[9]. The criteria of who is eligibility for the RAA is not transparent or widely understood. Payments of the allowance are made separately from health workers' basic salary and often paid late in arrears due to poor administrative capacity in the MOHS. Not receiving RAA demotivates staff further and might reduce the motivation gained from DFID's support to the salary uplift.

The high turnover of staff within the MOHS has resulted in a loss of institutional memory and there are no perceptible gains from the capacity building initiatives associated with the overall project. This was due to posting within the civil service and internal postings within the MOHS and affected o senior management (e.g. four different directors have been appointed as the Director of the HRH directorate since the implementation of the FHCI)) as well as administrative support staff in the HRH Directorate. The latter group was engaged throughout the project implementation and individuals were trained on various aspects of the payroll management software and systems. Unfortunately of the five trained, only one remains as a member of staff within the HRH Directorate with the others being posted to other departments. This has had a negative impact on the sustainability of the project and further incapacitated the MOHS. Any new programme of support should be mindful of the frequency of internal postings and changes of leadership that occur in the MOHS and put mechanisms in place to ensure effective staff handovers to build institutional memory.

In addition, the scheme of service, which would ensure that health workers' job designations matched grades, has not yet been finalised, as was recommended in the 2013 Annual Review. This has compromised progress made with regards to this output.

There are serious concerns about whether the GoSL can afford and sustain the public sector payroll. It currently accounts for 74% of revenue which is above the 50% level recommended by the International Monetary Fund. The is especially true in light of Sierra Leone's recent decline in economic growth due to the drop in the global Iron ore price and the decrease in revenue due to the Ebola outbreak. Health workers already make up 51% of the civil service[10] and the numbers will increase if the Government keeps it pledge to absorb the Ebola workers onto the payroll. The downstream effect of not maintaining the salary uplift will reverse the gains made by the FHCI in contributing towards strengthening the HRH pillar of the health system.

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[8] Witter, S., Wurie, H. and Bertone, M. (2015) The Free Health Care Initiative: how has it affected health workers in Sierra Leone (ReBUILD report available online)

[9]Wurie. H. and Witter, S. (2014) Serving through and after conflict: life histories of health workers in Sierra Leone. Report for ReBUILD (available online: http://rebuildconsortium.com/publications/documents/IDIreportSLfinal230614.pdf)

[10] To note the civil service does not include teachers who are employed by Government in a greater number than health workers.

HRH is prioritised under the health pillar of the President's Recovery Plan (May – December 2015) that aims to ensure health worker and patient safety and re-establish essential health services. DFID is funding the Clinton Health Access Initiative (CHAI) and World Health Organisation (WHO) to support the HRH Directorate to implement these priorities. They include conducting a comprehensive workforce audit, populating the HRMIS data base, cleansing the payroll and developing a workforce optimisation plan. This support will provide the MOHS with a sound evidence base and information systems to better manage the health workforce going forward. The evidence will also inform DFID's decision on any future support to HRH.

DFID providing budget support to the GoSL was a good initiative with regards to strengthening the systems and contributing towards sustainability in the long run. This approach should be built upon and encouraged with other donors to maximise aid effectiveness in Sierra Leone.

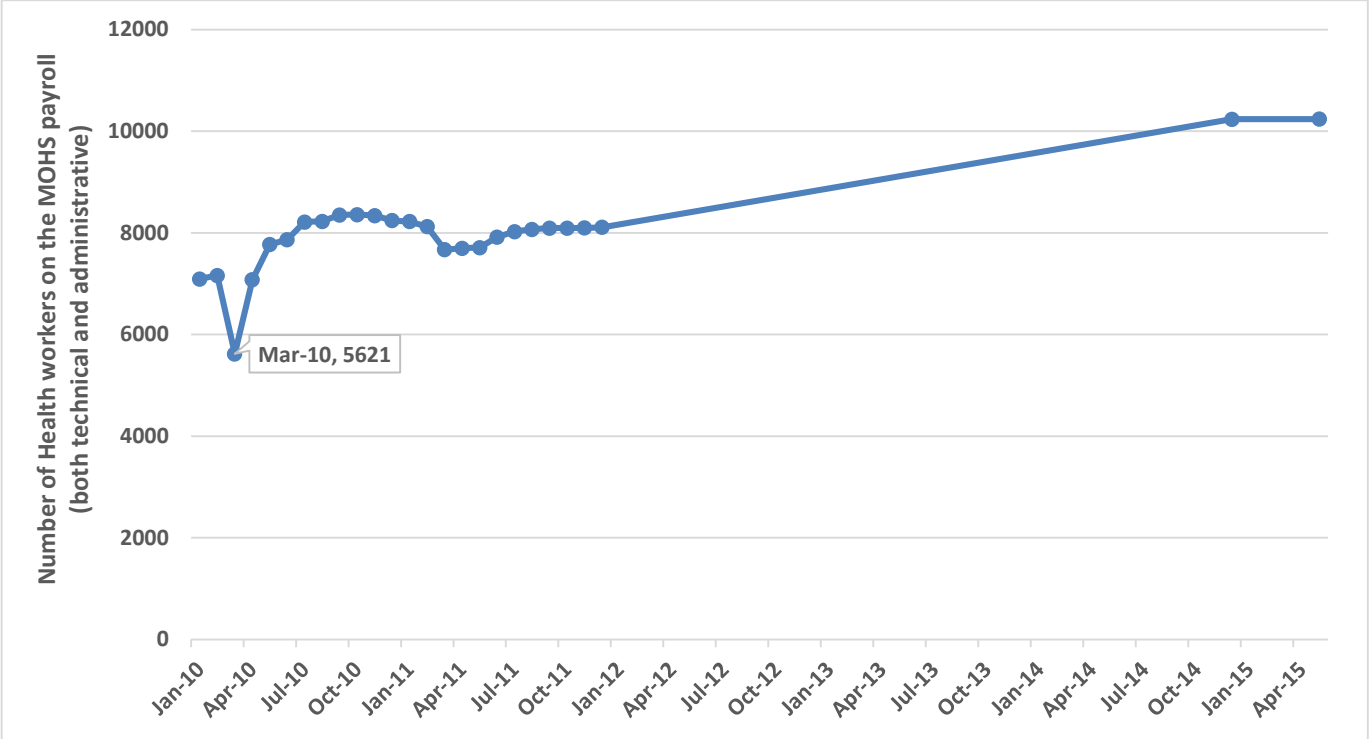

Figure 1: Trend in number of MOHS staff (technical and administrative) pre and post FHCI

Summary of responses to issues raised in previous annual reviews (where relevant)

1. The scheme of service developed in 2011 is not yet finalised. This is due to the Pay and Grade committee, which is made up of top civil servants, not being able to meet and finalised the scheme of service. The recommendation that TA should be provided to review and complete the scheme has not been done.
2. TA was provided to support the MOHS HRH Directorate with the payroll management system and to modify the payroll system to enable the production of consolidated data on staff numbers by job title and grade at facility, district and central level. However the payroll software was not updated or improved and adequate training by the TA to allow the local staff to operate the system was not conducted. This was due to the limited and fragmented timeframe of the provision of TA. A new payroll management consultant is now being recruited by the MOHS paid for by the GFATM.

Recommendations

For GoSL/MOHS

1. Concerted effort is needed from the HRH Directorate, the Health Service Commission (HSC), HRMO and other relevant organisations to ensure that the Scheme of Service is revised, finalised and approved by the Pay and Grading Committee to ensure that health workers' job designations match grades.
2. The payroll database needs to be cleaned and updated regularly, especially in light of the EVD outbreak. The GFATM funded TA position should be filled as a matter of urgency.

3. Future support should focus on district and health facility management of human resources in support of the decentralisation policy and to build resilience of the health system. Districts should be made responsible for a number of relevant indicators within the PSC to strengthen accountability.
4. The payroll software should be modified to enable the generation of consolidated data on health worker stock, distribution and characteristics at facility, district and central levels.
5. MOHS needs to make it transparent as to who is eligible for incentive payments/allowances and should integrate all allowances onto the payroll system. Innovative health worker and payment tracking systems should be explored, such as the use of mobile phones money transfers to ensure that incentives reach health workers in a timely manner.

For DFID/other development partners

6. DFID should explore the feasibility of continued support to health workers salaries and human resource management system strengthening to safeguard the gains made through this project. Support should be considered for the central and district level.
7. If future programmes include TA it should be done in a way that avoids fragmentation and duplication and has clearly defined reporting structures so that it can be held accountable for the delivery of key milestones.

Output Title	Enhanced capacity of MOHS to manage human resources for health with respect to attendance and deployment		
Output number per LF	2	**Output Score**	***A***
Risk:	*High*	Impact weighting (%):	40%
Risk revised since last AR?	*N*	Impact weighting % revised since last AR?	*N*

Indicator(s)	**Baseline**	**2014 data value and scores**	**2015**		
			Planned	**Achieved**	**Grade**
Districts and hospital attendance reports reach HRH/MOHS by the 25th of every month as defined by AG	0% (system in place from September 2010)	98.6% A	100%	**n/a**	**n/a**
Facilities attendance reports to district are captured in the district monthly attendance tool	n/a	88% A	95%	**n/a**	**n/a**
Monitoring of the attendance process by MOHS/HRH	89% (in December 2010)	24% C	60%	**n/a**	**n/a**

Data on the milestones is not available for 2015 due to the lack of reporting during the Ebola outbreak. However, in general good progress was made with developing the capacity of the MOHS to manage HRH with respect to attendance and deployment over the project's lifetime. Based on this the output has met expectations and has been scored an A.

In general it was reported that data management and capacity for monitoring and evaluation improved as a result of the project. TA was provided (from DFID's RMCH project) to support the HRH Directorate. This included elements of training and capacity building. However as discussed above, the high turnover of MOHS staff and civil servants within and between Ministries, Departments and Agencies (MDAs) has had a negative impact on building institution memory. In addition the salary uplift was only for the technical members of staff and not for administrative staff who are responsible for managing the payroll. This was reported as demotivating and could have had a negative effect on the management of the payroll and HR systems.

The performance of districts and hospitals in reporting attendance in a timely manner improved over the project lifetime from having no attendance monitoring system in place to 98.6% of districts/hospitals reporting in 2014. Figure 2 below shows a positive impact of introducing the Conduct and Sanction Framework and the staff monitoring system on absenteeism; with levels reducing from 2.5% in 2010 to 1.1% in 2014. This was corroborated by the key informant interviews conducted as part of this review.

Payroll cleaning and maintenance resulted in the removal 'ghost workers' of 1000 'ghost workers' from the payroll and led to a total estimated saving of $699,000 over the period March 2010 to May 2012 ($408,200 from the payroll cleaning exercise and $290,800 after the introduction of the Conduct and Sanction Framework). This highlights the added economic incentive to the MOHS of implementing the Conduct and Sanction Framework. These reported gains must be maintained by continuing spot-checks to ensure that the reported data on staff attendance is robust and reliable.

As a result of the challenges described under output 1 the HRH Directorate is inadequately equipped, in terms of resources, trained capacity and funding to conduct effective monitoring and verification exercises at the national level. These compromises the sustainability of the progress made. Spot check exercises conducted by GFATM in 2014 also highlighted challenges in HRH management (e.g. health workers on

the payroll but not on the attendance list) which resulted in the GFATM suspending their funding to the RAA. This highlights the need for continued support to M&E systems.

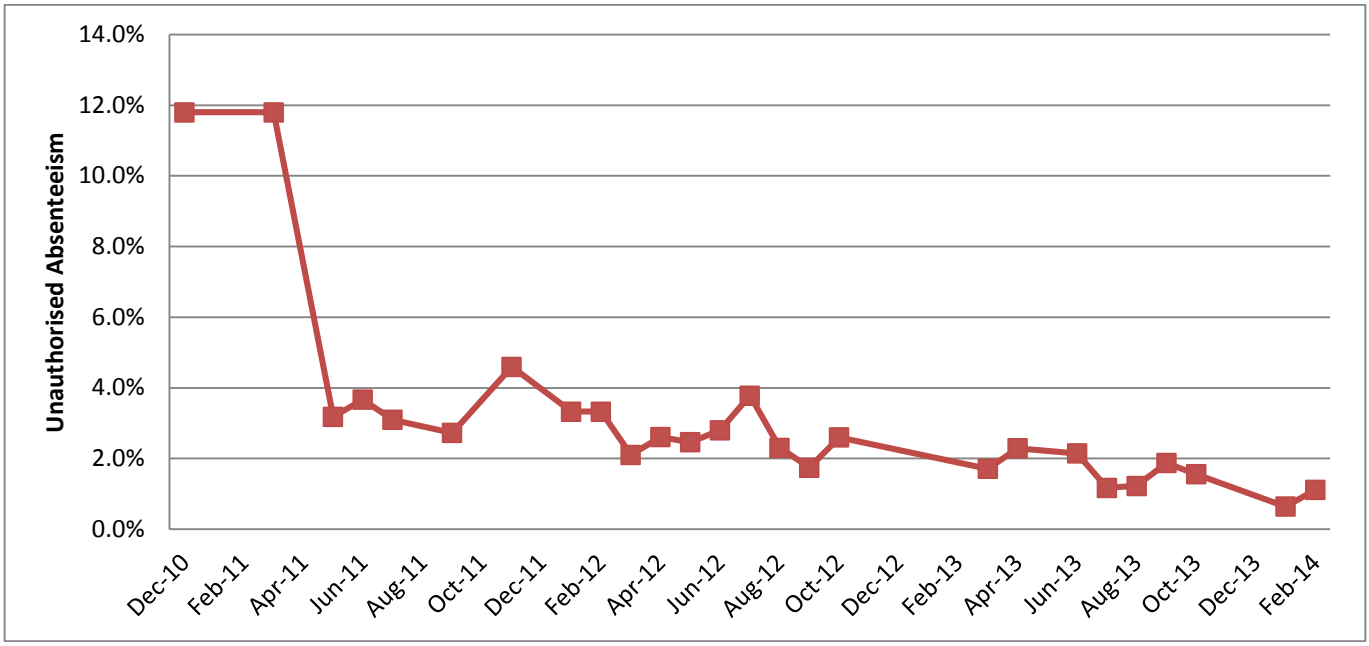

Figure 2: National trends in unauthorised absenteeism

(Note: Unauthorised absenteeism calculated as 'staff with one or more days of unauthorised absence /number of staff on payroll)[11]

The target for monthly amendment forms from the MOHS processed correctly by the AGD/HRMO was also met over the project's lifetime. The milestone was reduced in 2013 to 87% from 98% in 2012 by the PSC, implying that challenges were faced with achieving this target. One such challenge includes staff turnover and changes in systems at HRMO. It was also reported from the key informant interviews that more work needs to be done on strengthening the coordination and communication and data exchange channels between the MOHS, AGD and HRMO.

The reported frequency of monitoring visits to districts substantially did not meet the milestone throughout the project's lifetime. This could be due to a number of reasons including a lack of resources to facilitate visits and the continued absence of funding allocated for monitoring and evaluation. The attendance monitoring at district level only commenced in March 2014 as part of the national integrated monitoring system and as such, only 24% of the 75% milestone was achieved. As the EVD outbreak restricted movement hampered the ability of the MOHS to conduct monitoring visits. So even though there has not been good progress in this area it was deemed unfair to score the output down because of it.

Recommendations
For GoSL/MOHS

1. The partnership between MOHS, AGD and HRMO should be further strengthened and effective mechanisms established to improve communication and coordination between relevant directorates (HRH, Financial Resources, and Health Systems Policy, Planning and Information) to ensure the continued effective management of the health workforce.
2. The feasibility of establishing HRH support units at the district level should be explored to further strengthen the capacity of MOHS to manage HRH with respect to monitoring and supervision.
3. The GoSL and MOHS should carefully consider the affordability and sustainability of absorbing EVD workers onto the payroll. Any recruitment and deployment of Ebola workers must address the skills and needs gap in the health sector and be financially sustainable.

[11] Wurie, H., Samai, M. and Witter, S. (2014) Staffing the public health sector in Sierra Leone, 2005-11: findings from routine data analysis. Report from ReBUILD (available online: http://rebuildconsortium.com/publications/documents/Project2Secondarydatareportfinal071114.pdf)

4. Having a functional and fully supported national HRMIS is an urgent priority in the immediate post EVD recovery plan. Districts must be supported to keep records up to date and regularly feed reports into the central HRMIS database.
5. Support districts to manage staff locally and have the ability to appoint, deploy, and discipline health workers. Make districts responsible for specific indicators, with their own benchmarks, could strengthen the accountability of the system.
6. MOHS should publish the criteria that determine which health workers are eligible for incentive payments/allowances and use mobile phone money transfer platforms to make timely payments.
7. Explore innovative techniques around monitoring and verifying staff attendance, such as mobile supervision applications to do spot-checks. This could be used locally and involve community monitors to report on attendance/absences as well as fee-charging for FHCI eligible groups.

For DFID/other development partners

8. Explore the possibility of increasing the salaries of key administrative staff in the MOHS in any future programme.
9. Support the HRH Directorate with financial resources (including communication), logistics and manpower to carry out monitoring and verification exercises effectively, using the HRH monitoring tool, and to manipulate the data to generate reports.
10. Support district and hospital management to monitor and report on HR and use the data for the management of their workforce.

Output Title	Effective community oversight of Free Healthcare Initiative (FHCI) by civil society		
Output number per LF	3	**Output Score**	***n/a***
Risk:	*High*	Impact weighting (%):	25%
Risk revised since last AR?	*Y/N*	Impact weighting % revised since last AR?	*N*

Indicator(s)	**Baseline**	**Progress and score (up to 2012)**
Extent of progress in developing a robust CSO monitoring system generating evidence on FHCI performance for MOHS and districts	No CSO monitoring system in place	Monthly reports generated by HFAC to MOHS, Districts and stakeholders including UNICEF and UNFPA – particularly on FHCI drugs and supplies in health centres. 2013 HFAC Monitoring report published on FHCI. B
Percentage of monitors who meet the criteria for effective CSO monitoring of (i) staff unauthorised attendance (ii) drug charging and (iii) treatment charging during HFAC quality assurance spot-checks	n/a	n/a
Extent of relationship between HFAC and Anti-Corruption Commission (ACC)	Informal relationship between HFAC and ACC	Joint working with ACC and police on prosecution of health workers B

This activity was supported by DFID's RMCH project, which provided funding until March 2012. There were no milestones set after this point therefore the score of this output is not included in the overall score of the project for 2015.

Financial support from DFID, through Options was provided to the Health For all Coalition, a civil society organisation, to engage in effective community oversight of the FHCI, through their nationwide network of chiefdom monitors (3 in every ward). This support greatly improved community based monitoring and the generation of evidence on the performance of the FHCI. It was reported that DFID's support improved HFAC's credibility at the community level and established accountability structures. However, HFAC reported that the funding was inadequate for comprehensive and regular monitoring of the FHCI. Drug supplies and maternal deaths were reported on a weekly basis. Reporting on other activities such as staffing at the health facilities and the charging of user fees to the FHCI target groups was limited to annual reporting, highlighting the need for more trained M&E officers and resources to improve monitoring and frequency of reporting at the community level. Specialist M&E support was also needed to improve on their community based activities and ensures data quality checks were in place. Very few of these monitoring activities were sustained once funding ended. HFAC is still generating weekly monitoring reports on the health sector with funding from other sources. These reports are shared with the relevant parties on a regular basis.

There was a signed memorandum of understanding between Anti-Corruption Commission (ACC) and HFAC that involved a joint programme of work with reporting systems to the MOHS, districts and other stakeholders. This operated largely on an alert platform, with HFAC taking the role of whistle-blowers with little reported collaboration from the MOHS.

It was recommended in the 2014 AR that MOHS senior management team should ensure that reported incidences of theft were adequately investigated with the support of senior members at district level. This recommendation was not fully addressed during the lifetime of the project. The prosecution of health facility staff proved to be difficult, primarily because the lack of coordinated action between the MOHS and HRMO prohibited the thorough investigation of allegations. However, prosecutions did take place at district level in Bonthe and Pujehun.

Recommendations

For DFID/other development partners

1. There is a need to strengthen the link between community, the service providers and central decision making bodies to ensure effective community engagement. DFID should explore how it can build on the community engagement generated though the HFAC, and during the Ebola response to improve the accountability of providers and Government for the delivery of basic services.

D: VALUE FOR MONEY & FINANCIAL PERFORMANCE (1 page)

Key cost drivers and performance
The key cost driver on this programme was the financial support given to the GoSL to increase health worker salaries. This amounted to £**10,030,161** over the project lifetime.

VfM performance compared to the original VfM proposition in the business case
The original project memorandum did not include a Value for Money (VfM) framework, as it was approved before this became a DFID requirement. Therefore there are no VfM metrics and developing and applying them in retrospect is not good practice. However, a VfM assessment can be framed around the four E's: economy, equity, efficiency and effectiveness.

Economy: In terms of economy, financial statements show that the salary uplift took place across the whole workforce thereby achieving economies of scale. Records show that the funds were disbursed from DFID's account to a consolidated central pool account in the Ministry of Finance and Economic Development, who then disbursed the uplift through the existing payroll system. This minimized the transaction costs of the salary uplift to DFID, the Government and health workers. Currently on average a medical officer in Sierra Leone earns $800, which is comparable with what is earned in the region (Guinea and Liberia).

Equity: The programme has contributed in providing equitable access to health care services to vulnerable groups in society. It has not addressed the mal-distribution of the health workforce due to challenges with the remote area allowance incentive scheme, designed to attract and retain health workers in rural postings.

Efficiency: There have been no reported delays in paying salaries to health workers, with the expectation of those in very remote areas that do not have access to banks and have to travel to district capitals to withdraw cash. Unauthorised absenteeism reduced from 12.5% (pre FHCI) to 1.1% (in February 2014) which implies that efficiency gains were obtained from each salary payment as health workers in post are assumed to be productive.

Effectiveness: The project has succeeded in motivating the health workforce to a certain extent and contributing towards the overall goal of supporting the successful implementation of the FHCI. The salary uplift was reported as being an attracting factor to join the health profession; however the quality of care that the health workers provide and the availability of other inputs (such as drugs, medical equipment and health infrastructure) will influence the effectiveness off the investment to deliver improved health outcomes for mothers and children.

Assessment of whether the programme represented value for money
The Conduct and Sanction Framework and the payroll cleansing exercise collectively helped the GoSL save $699,000 on the wage bill. Effective and continuous implementation of the sanction framework will help with its management. However, the GoSL should carefully consider the affordability and sustainability of the wage bill in light of Sierra Leone's economic downturn.

Quality of financial management during the programme
From the inception of the project until June 2012, DFID payments to GoSL were made via Crown Agents Bank, who then disbursed the funds to GoSL. From June 2012 DFID's financial aid policy changed and payments were made directly to GoSL from DFID. Disbursements to the GoSL occurred generally in line with the payment schedule. The amount released also depended on progress made against the agreed logframe milestones. Payments to the GoSL were reduced due to MOHS's failure to meet some of the performance indicators as shown in the financial summary table below, which led to £600,000 of the funding not being disbursed.

The project faced challenges on the timeliness and quality of the audits received from the GoSL. According to the terms of the Memorandum of Understanding (MoU) between DFID and the GoSL, the GoSL should provide DFID with annual audited statements for the project nine months after the end of each financial year. An audit statement covering August 2010 to June 2011 was received in July 2011 on time. However, despite repeated communication with the Ministry of Finance and Economic Development (MOFED) and the Audit Service for Sierra Leone, no audit covering the July 2011 to June 2012 or for July 2012 to June

2013 periods were received. This resulted in a breach of the terms of the MoU and after discussions with the GoSL, DFID suspend the disbursement of funds in November 2013.

In April 2014 the Audit Service of Sierra Leone submitted an audit statement covering the period July 2011 to Dec 2013. However, the report was found to contain several inaccuracies due to missing documentation and did not reconcile with DFID's financial reports. An extraordinary audit report was requested, and in September 2014 DFID received revised Annual Audited Accounts covering the period 31st July 2011 to 31st December 2013 (Quest No. 4666389). These reconciled with DFID's financial records (Quest No. 4555679) and triggered the recommencement of disbursals in September 2014. The remaining funds were disbursed according to a schedule agreed with the GoSL. The MOFED explained that as DFID funds were released into a central consolidated fund account this had made providing audited accounts on DFID's contribution particularly challenging.

The GFATM suspended the disbursements of its funding in June 2014, citing the poor quality of the audit report received from the MOHS on the RAA. In addition the GFATM's Local Funding Agency (LFA) conducted a health worker verification exercise in 2014 and found discrepancies with what was reported by the MOHS. The GFATM is planning to commission an external audit of the MOHS managed account.

The table below shows the project financed over the implementation years by UK financial year.

Financial year	**Value (£)**	**Notes**
2010/11	3,300,000	An additional £300,000 was approved to offset a backlog in salary payments
2011/12	2,350,000	Payments reduced by £125,000 due to underperformance against milestones.
2012/13	1,880,000	Payment reduced by £125,000 due to under-performance against milestones.
2013/14	750,000	Payment reduced by £50,000 due to under-performance against milestones.
Disbursals were suspended in November 2013		
2014/15	£1,187,500	
Total Disbursed	**£9,467,500**	Payments reduced by £600,000 due to MOHS' failure to meet some of the performance indicators for the review period
VSO personnel	£416,037.24	
Project Evaluation	£146,623.85	
Project total	**£10,031,161.09**	

Date of last narrative financial report	Not Applicable
Date of last audited annual statement	9th September 2014

E: RISK (½ page)

Quality of risk management over the life of the programme

The risk for the project remained high throughout its lifetime as there was a high risk of funds not being used as intended. To mitigate these public financial management indicators were tracked by the PSC, performance against which triggered the release of DFID funds:

- Degree of integration and reconciliation between personnel and payroll data;
- Timeliness and internal controls of changes to personnel records and the payroll; and
- Existence of payroll audits to identify control weaknesses and/or ghost workers.

Mitigation of the overall risks was better managed in the initial phase of the programme. TA was in place to oversee the administration of payroll administration and attendance monitoring systems, which mitigated the risks considerably. However, TA oversight was not available from 2013 onwards, and this combined with high turnover of staff from the HRH Directorate meant the risks were not so closely managed. The MOHS currently lacks the technical expertise to update the health workers attendance and monitoring tool and TA is still needed to mitigate the risk. The GFATM has made funds available for this TA and recruitment is underway. DFID is funding CHAI to support the HRH Directorate to implement the HRH priorities under the President's Recovery Plan but this support is only until February 2016.

It was reported that some of the issues raised in the GFATM' s 2014 health workers' salaries spot check report had been addressed by the PSC. The PSC was expected to update the risk mitigation plan for 2014/2015, but it is unclear if this was done as a consistent set of minutes from the PSC meetings were not readily available.

F: *COMMERCIAL* CONSIDERATIONS (½ page)

Delivery against planned timeframe

There are minimal commercial considerations as the bulk of the projects went directly to the GoSL. However, the financial aid being provided was subject to certain conditions between DFID, the MOHS and the MoFED, as captured in the MOU. These conditions included:

- Establishment of key indicators and benchmarks used to monitor the performance and integrity of the health workers monthly payroll. Penalties were applied if under-performance was reported against the set milestones;
- Production of timely monthly reports that demonstrate the integrity of the payroll has been maintained; and
- The suspension of funds in the event that the integrity of the payroll has been compromised.

On the whole the project was on target to deliver against its timeframe. The suspension of the disbursement of funds from DFID in November 2013 disrupted the plan payment schedule. This was amended and DFID released the suspended funds in November 2014 and January 2015.

Performance of partnership(s)

This programme was designed to strengthen donor partnerships and inter and intra sectoral partnerships between the MDAs. GFATM and DFID collaborated closely in implementing the tripartite agreement for joint contributions to health workers salaries. This collaboration was maintained throughout the project implementation period, including joint DFID/GFATM meetings with the Minister of Health to discuss performance.

Senior Management at the MOHS provided oversight of the project. The MOHS should however put systems in place to manage the high turnover of senior management in the MOHS. HRMO also had a change in leadership in July 2013 which affected the timely amendments to the payroll and was the primarily reason for the reduction in two of the three planned disbursements. More coordination was needed from the senior management at the MOFED. It was reported in the 2014 AR that *'the Ministry of Finance support to the programme continues to be less than satisfactory with sporadic attendance by junior staff at meetings'.* With the intervention of the Minister of Health, there was a notable improvement in amendment processing and increased engagement of the HRMO. The PSC (with representatives from MOHS, MOFED, DFID, HRMO, GFATM) meetings also created an ideal collaborative platform. These

meetings were described as operational involving management people that could work with implementers. The partnership with VSO was also satisfactory.

Asset disposal and value obtained by DFID
There are no DFID owned assets administered by this project.

H: MONITORING & EVALUATION (½ page)

Evidence and evaluation

An external evaluation of the programme was conducted in September 2012 which concluded that 'it can be said with confidence that the salary uplift was critical to the success of the FHCI thus far' but significant challenges remained. A final evaluation was planned for 2014/15 to inform the PCR and give recommendations for DFID's further support to HRH through the DFID BPEHS programme. This evaluation did not take place due to the EVD outbreak. DFID's BPEHS project is now being reviewed and in the post Ebola situation is more likely to focus on supporting district level delivery rather than central level TA on issues such as HRH. However, the recommendations from this review and CHAI's support to the HRH Directorate will help inform DFID's support to the health sector in the medium term.

The 2012 evaluation highlighted several key issues including the necessity of having technical support to consolidate achievements made with maintaining payroll integrity, institutionalizing a credible attendance monitoring system and ensuring systems were integrated fully into HRH management systems. However, a number of these issues were not adequately addressed during the project. With regard to the payroll system, inadequate infrastructure, systems security and the limitations of the system for wider HRH data management were some of the challenges identified. TA support to the HRH Directorate, was provided in a fragmented manner and staff trained were not retained.

The evaluation suggested that although the FHCI policy was generally enforced, the target group were still being asked to make some level of payment in some instances. This was also reported during the key informant interviews conducted as part of this review. Further elucidation of this practice will need to be determined as this undermines the overarching goal of the project and may compromise DFID's contribution towards maternal and child health outcomes in Sierra Leone. Accordingly the evaluation report recommended that the project's emphasis should shift from strengthening payroll and attendance systems, to developing systems to ensure greater enforcement of the non-user fees for target groups. However, the logframe was not revised to reflect this and community level monitoring by CSO tasked with generating data on user fees was not continued.

The decreased functioning of the MOHS payroll and attendance monitoring system in the absence of TA and the waning attention of key players, including the MOFED, suggests that the right incentives and attitudes to sustain institutional engagement and reforms are not yet in place. The FHCI impact evaluation study, shortly to commence, will examine the political and technical influences on the implementation of the policy.

The 2012 evaluation confirmed that the GoSL was on track to absorb the full cost of health workers salaries by 2015. However, this might not be the case now due to the economic downturn and addition of the Ebola workers onto the Government payroll. The EVD outbreak has brought these health systems challenges into sharp focus and there may be an opportunity to advocate and push for more sustainable health reforms during the post EVD recovery phase.

Overall, the project's theory of change continues to hold true with a reduced level of FHCI beneficiaries fees levied and increased utilization of FHCI services compared to pre 2010 figures.

Monitoring progress throughout the programme

Measures were put in place to monitor the progress of the project throughout its implementation period. The project contributed greatly to the M&E architecture at the national, district and community level. HFAC were supported to provided community level monitoring of the FHCI and reported in 2013 that 93.5% of beneficiaries of FHCI indicating their willingness to visit the same facility in future as they were satisfied with the services being offered. However challenges exist for the stabilization in utilization of FHCI services, and challenges in maintaining consistent level of essential drugs and staffing at health facilities. These challenges are being addressed by other DFID projects with support being given to UNICEF to support the National Pharmaceutical Procurement Unit to reduce stock outs. The ReBUILD project continues to generate evidence based findings on the HRH challenges, and the factors that motivate and demotivate health workers in Sierra Leone.

Monitoring and supervision by the HRH Directorate was inadequate as the resources and funding for effective monitoring were lacking. The Directorate did conduct a monitoring visit in April 2014 as part of the quarterly MOHS national integrated health sector supervision visits. Subsequent supervision visits in 2014 were disrupted by the EVD travel restrictions introduced. Other DFID funded programmes, i.e., IRMNH and Evidence for Action for Reduction of Maternal and Child health programmes also engaged in monitoring and helped keep DFID informed of the situation on the ground. GFATM healthcare workers' salaries spot check also acted as an additional source of information. Lastly the PSC meetings provided monitoring of the project, as its assessment of milestones triggered the disbursement of funds.

Limitations to the PCR process

The PCR was conducted with the review of documentation and key informant interviews. However the following limitations in the review are acknowledged:

i. A final evaluation was not conducted so recent consolidated data was not available. This may affect the conclusions of this review.
ii. The 2014 EVD outbreak disrupted a number of GoSL and DFID administrative activities pertaining to project implementation and monitoring. The PSC meetings also ceased during this time.
iii. The project was designed prior the DFID required projects to have VfM frameworks. Therefore it was not possible to conduct a VfM analysis of the project.
iv. The 2009 logframe included milestones up to 2014 but the revised logframe of July 2011, which superseded it, only had milestones until 2013. Milestones were agreed for 2014 and 2015 by the PSC. Documented evidence of achievement against these milestones was not available during the review process.
v. The logframe included indicators to judge outputs that were not funded by the project but had been funded by other DFID projects and donors, raising the issue of attribution of this project to the outcome.

Appendix: Risk register and mitigation strategies

Type of Risk	Probability (3 high, 1 low)	Impact (3 high, 1 low))	Mitigation strategies	Mitigation potential
The Ministry of Health payroll becomes corrupted	3	3	Specialised technical assistance is being recruited to both build the capacity of Government to manage the payroll and to provide first hand data on its integrity on a monthly basis. Decisions for disbursal will be made against this.	High
The payroll becomes bloated and there are insufficient funds from either Government or donors to pay health workers	2	3	Long-term technical support is working with MoH's Human Resources Team to strengthen workforce planning and better project personnel needs against available funds. The development partners need to work closely with MoFED to ensure budget gaps are firstly identified and then filled. UNICEF and DFID are taking the lead on this now, asking for Government allocations over the coming 5 years on which to base the donor response on. It is hoped that GFATM funds will support salary costs over the next 5 years. In addition The World Bank's 2nd RCH project is coming on stream and we are looking to encourage others, including Irish Aid to provide resources. UNICEF Sierra Leone is undertaking a Scandinavian country tour to recruit contributors in the coming months.	Medium
Health workers start charging again to increase their salaries further	3	3	This would undermine the purpose of our significant human and financial contributions to the launch and implementation of the FHCI. Government have recently introduced clear sanctions and codes of conduct for health workers. The anti-Corruption Commission are also involved in the monitoring of the implementation of the initiative. Free mobile phones will be installed in health facilities for patients to report any deviation from the free health care policy by staff. A proactive media campaign remains live to inform the general public about the FHCI and their rights and the service they should receive.	High
Health outcomes do not improve despite the introduction of free health care for the targeted groups	2	3	DFID will undertake a nationwide in depth analysis of the impact of the FHCI and our support to it in May 2011. Future funding decisions will take the conclusions and data from this study in to consideration.	Medium
At the end of the 5 year programme	2	2	DFID along with the rest of the Poverty Reduction Budget Support donors are	Medium

our exit strategy maybe not be clear unless Government revenue collections have increased substantially.			pushing Government hard on improving the effectiveness of its revenue collection systems and policies. DFID is funding a large reform programme of the National Revenue Authority, the goal of which is to see a step change in the level of revenue the Government collects.	

OUTPUT 1	Indicator 1	Baseline 2010	Milestone 1 2011[12]	Milestone 2 2012	Milestone 3 2013	Milestone 4 2014	Milestone 5 2015[13]
Health payroll managed effectively	Percentage of staff with official job designation (Percentage of staff with a substantive job designation on the payroll)	53%	98%	98%	98%	95%	95%
			Achievement 1 2011	**Achievement 2 2012**	**Achievement 3 2013**	**Achievement 4 2014**	**Achievement 5 2015**
			99.7%	**100%**	**97%**	**98.4%**	**Not known**
		Source					
		MoHS staff list informing payroll. Baseline is from Feb 2010 AG Payroll (3778/7164)					
	Indicator 2	**Baseline 2010**	**Milestone 1 2011**	**Milestone 2 2012**	**Milestone 3 2013**	**Milestone 4 2014**	**Milestone 5 2015**
	Staff with a defined workstation who are on the payroll (Percentage of staff with correct workstation listed on the payroll)	32%	98%	98%	98%	85%	95%
			Achievement 1 2011	**Achievement 2 2012**	**Achievement 3 2013**	**Achievement 4 2014**	**Achievement 5 2015**
			98.8%	**98.6%**	**90.1%**	**90.3%**	**Not known**
		Source					
		MoHS staff list informing payroll (*Baseline: 2987/9433 records with unknown workstations in March 2010 (i.e. not found in headcount but on payroll)					
IMPACT WEIGHTING	**Indicator 3**	**Baseline 2010**	**Milestone 1 2011**	**Milestone 2 2012**	**Milestone 3 2013**	**Milestone 4 2014**	**Milestone 5 2015**
35%	% of health workers with job description that matches grade (Percentage of staff with a job designation that matches their pay grade)	Approx 53%	97%	98%	98%	95%	95%
			Achievement 1 2011	**Achievement 2 2012**	**Achievement 3 2013**	**Achievement 4 2014**	**Achievement 5 2015**
			97%	**97.2%**	**95.8%**	**95.6%**	**Not known**
		Source					
		MoHS payroll (Baseline: count is same as those without clear job designations; exact figure unknown as job grade/designations also changed in FHC and subsequent adjustments were made)					
	Indicator 4	**Baseline 2010**	**Milestone 1 2011**	**Milestone 2 2012**	**Milestone 3 2013**	**Milestone 4 2014**	**Milestone 5 2015**
	Percentage of staff reported on study leave with authorisation from HRMO[14]		**N/A**	**N/A**	**N/A**	**50%**	**50%**
			Achievement 1 2011	**Achievement 2 2012**	**Achievement 3 2013**	**Achievement 4 2014**	**Achievement 5 2015**
			N/A	**N/A**	**N/A**	**N/A**	**Not known**

[12]Data on achieved milestones from Evaluation of DFID Support to Healthcare Workers Salaries in Sierra Leone (2012) for the yeat 2011
[13] Documented evidence not available at the time of the review to assess indicators for 2015
[14] New performace indicator added by the Payroll Steering Committee for 2015 *(wording of revised indicators by PSC in red for 2015).* Milestones set by PSC from 2013 - 2015

OUTPUT 2	Indicator 1	Baseline 2010	Milestone 1 2011	Milestone 2 2012	Milestone 3 2013	Milestone 4 2014	Milestone 5 2015
Enhanced capacity of MOHS to manage human resources for health with respect to attendance and deployment	Districts and hospitals report attendance for month 0 by the end of the month 1 (Districts and hospital attendance report attendance reach HRH/MOHS against the 25th of every month as defined by AGD)	0% - System in place from Sept 2010	100%	100%	100%	98%	100%
			Achievement 1 2011	**Achievement 2 2012**	**Achievement 3 2013**	**Achievement 4 2014**	**Achievement 5 2015**
			96%	**88%**	**94%**	**98.6%**	**Not known**
		Source					
		MOHS payroll monitoring system					
	Indicator 2	**Baseline 2010**	**Milestone 1 2011**	**Milestone 2 2012**	**Milestone 3 2013**	**Milestone 4 2014**	**Milestone 5 2015**
	Monthly amendment forms from MoHS correctly processed by AG/HRMO (Facilities attendance reports to district are captured in the district monthly attendance tool)	89% in December 2010	95%	98%	98%	87%	95%
			Achievement 1 2011	**Achievement 2 2012**	**Achievement 3 2013**	**Achievement 4 2014**	**Achievement 5 2015**
			99.6%	**85.7%**	**90%**	**88%**	**Not known**
		Source					
		Reports from HRH Support Unit					
IMPACT WEIGHTING	**Indicator 3**	**Baseline 2010**	**Milestone 1 2011**	**Milestone 2 2012**	**Milestone 3 2013**	**Milestone 4 2014**	**Milestone 5 2015**
40%	Attendance process and monitoring visits completed (includes check on physical presence of staff and confirmation of attendance process). (Monitoring of the attendance process by MOHS/HRH)	N/a	Detailed plan in place and being implemented	At least 10% of all facilities visited in one year	At least 10% of all facilities visited in one year	At least 10% of all facilities visited in one year – 75%	60%
			Achievement 1 2011	**Achievement 2 2012**	**Achievement 3 2013**	**Achievement 4 2014**	**Achievement 5 2015**
			N/A	**>10%**	**~10%**	**24%**	**Not known**
		Source					
		HRH and DPI, MoHS monitoring plans					

OUTPUT 3	Indicator 1	Baseline 2010	Milestone 1 2011	Milestone 2 2012	Milestone 3 2013	Milestone 4 2014	Milestone 5 2015
Effective community oversight of Free Healthcare Initiative (FHCI) by civil society	Extent of progress in developing a robust CSO monitoring system generating evidence on FHCI performance for MOHS and districts	No CSO monitoring system in place	CSO monitoring system developed and piloted	CSO monitoring system rolled out and effectiveness assessed	Robust CSO monitoring system in place and reporting regularly to MOHS, districts and other stakeholders	N/A	N/A
		Progress: Monthly reports generated by HFAC to MOHS, Districts and stakeholders including UNICEF and UNFPA – particularly on FHCI medicines and medical supplies in health centres. 2013 HFAC Monitoring report published on FHCI.					
		Source					
		HFAC quarterly monitoring reports					
	Indicator 2	**Baseline 2010**	**Milestone 1 2011**	**Milestone 2 2012**	**Milestone 3 2013**	**Milestone 4 2014**	**Milestone 5 2015**
	% monitors who meet the criteria for effective CSO monitoring of (i) staff unauthorised attendance (ii) drug charging and (iii) treatment charging during HFAC quality assurance spot-checks	Not known	50%	60%	75%	N/A	N/A
		Progress: N/A					
		Source					
		HFAC Spot-check Form (to be developed with monitoring consultant) with results compiled in HFAC quarterly reports					
IMPACT WEIGHTING	**Indicator 3**	**Baseline 2010**	**Milestone 1 2011**	**Milestone 2 2012**	**Milestone 3 2013**	**Milestone 4 2014**	**Milestone 5 2015**
25%	Extent of relationship between HFAC and Anti-Corruption Commission (ACC)	Informal relationship between HFAC and ACC	Signed Memorandum of Understanding (MOU) between HFAC and ACC	Mechanism established for HFAC to report breaches of Sanctions and Conduct Framework and collaborating with ACC	Operationalised mechanism for reporting breaches of Sanctions and Conduct Framework and active collaboration with ACC	N/A	N/A
		Progress: Joint working with ACC and police on prosecution of Health workers					
		Source					
		Signed MOU, minutes of meetings, records of breaches reported to ACC					

Smart Guide

The Programme Completion Report is the opportunity to reflect on the entire programme, its performance, achievements, and lessons and how learning will be shared to inform future programming.

The Programme Completion Report assesses and rates outputs using the following rating scale. ARIES and the separate programme scoring calculation sheet will calculate the overall output score taking account of the weightings and individual outputs scores

Description	Scale
Outputs substantially exceeded expectation	A++
Outputs moderately exceeded expectation	A+
Outputs met expectation	A
Outputs moderately did not meet expectation	B
Outputs substantially did not meet expectation	C

Teams should refer to the considerations below as a guide to completing the annual review template.

Summary Sheet

Complete the summary sheet with headline information on the programme and any follow up actions

Introduction and Context

Briefly outline the programme, results achieved and contribution to the overall Operational Plan and DFID's international development objectives. Where the context supporting the intervention has changed from that outlined in the original programme documents explain what this will mean for UK support

B: Performance and conclusions

Outcome Assessment

Brief assessment of whether the programme achieved the Outcome

Overall Output Score and Description

Progress against the milestones and results achieved that were expected as at the time of this review.

Lessons

Any key lessons you and your partners have learned from this programme

Have assumptions changed since design? Would you do differently if re-designing this programme?

How will you and your partners share the lessons learned more widely in your team, across DFID and externally

C: Detailed Output Scoring

Output

Set out the Output, Output Score

Score

Enter a rating using the rating scale A++ to C.

Impact Weighting (%)

Enter the %age cannot be less than 10%.

The figure here should match the Impact Weight currently shown on the logframe (and which will need to be entered on ARIES as part of loading the Annual Review for approval).

Revised since last Annual Review (Y/N).

Risk Rating

Risk Rating: Low/Medium/High

Enter Low, Medium or High

The Risk Rating here should match the Risk currently shown on the logframe (and which will need to be entered on ARIES as part of loading the Annual Review for approval).

Where the Risk for this Output been revised since the last review (or since inception, if this is the first review) or if the review identifies that it needs revision explain why, referring to section B Risk Assessment

Key points

Summary of response to issues raised in previous annual reviews (where relevant)

Recommendations for future programmes

Repeat above for each Output.

D Value for Money and Financial Performance

Key cost drivers and performance

Consider the specific costs and cost drivers identified in the Business Case

Have there been changes from those identified in previous reviews or at programme approval. If so, why?

VfM performance compared to the original VfM proposition in the business case. Performance against VfM measures and any trigger points that were identified to track through the programme

Assessment of whether the programme represented value for money?

Overall view on whether the programme was good value for money

Quality of Financial Management

Consider our best estimate of future costs against the current approved budget and forecasting profile

Have narrative and financial reporting requirements been adhered to. Include details of last report

Have auditing requirements been met. Include details of last report

E Risk

Quality of risk management over the life of the programme. How were risks managed, the degree to which they were realised and/or mitigated.

F: Commercial Considerations

Delivery against planned timeframe. Y/N

Compare actual progress against the approved timescales in the Business Case. If timescales are off track provide an explanation including what this means for the cost of the programme and any remedial action.

Performance of partnership

How well are formal partnerships/ contracts working

Are we learning and applying lessons from partner experience

Could DFID be a more effective partner

Asset disposal and value obtained by DFID

How were assets managed throughout the programme? How have they been (or will they be) disposed to get maximum value?

H: Monitoring and Evaluation

Evidence and evaluation

Changes in evidence and implications for the programme

Where an evaluation is planned what progress has been made

How is the Theory of Change and the assumptions used in the programme design working out in practice in this programme? Are modifications to the programme design required?

Is there any new evidence available which challenges the programme design or rationale? How does the evidence from the implementation of this programme contribute to the wider evidence base? How is evidence disaggregated by sex and age, and by other variables?

Where an evaluation is planned set out what progress has been made.

Monitoring process throughout the programme
Direct feedback you have had from stakeholders, including beneficiaries
Monitoring activities throughout review period (field visits, reviews, engagement etc)
The Annual Review process