GOVERNMENT OF SIERRA LEONE

MINISTRY OF HEALTH AND SANITATION

HUMAN RESOURCES FOR HEALTH STRATEGIC PLAN

2012-2016

FOREWORD

Human Resource is a critical asset in the provision of equitable, affordable and accessible quality health care. Currently, the health sector in Sierra Leone is facing a major human resource crisis with shortages of health workers at every service delivery level. To address the current crisis it is essential that there should be adequate numbers and equitable distribution of appropriately skilled and motivated health workers.

The health workforce is relatively under remunerated and there has been stagnation and underinvestment in the development of Human Resource for Health and the health sector at large. Poor working conditions and poor human resource management systems are all contributory demotivating factors to the low performance of the health workforce. The development of the Human Resource for Health Strategic Plan is therefore timely and a major step in tackling the human resource challenges in a comprehensive and systematic way.

The Ministry of Health and Sanitation has developed this Strategic Plan in consultation with key stakeholders. The strategies and activities outlined in the Plan provide a frame of reference to guide and direct interventions, investments and decision making in the organization and growth of human resources for health. Specific focus is on leadership and governance, management, training, information and research, as well as partnerships and advocacy.

The Strategic Plan will also be used as an instrument for resource mobilization for the Ministry and partners. The successful implementation of the Plan will require strong and focused commitment of all stakeholders in the health sector. The deliverables, if the plan is well implemented, will include well trained staff with appropriate skills mix, successful retention strategies, competence building at various levels and adequate funding. Periodic reviews should be carried out to assess progress in the implementation of the Plan because of emerging and changing needs.

I have no doubt that the implementation of the Human Resource for Health Strategic Plan will initially be fraught with anticipated difficulties, but, with the commitment and unflinching support from Government, Development Partners, Civil Society, Private Sector, Professional Regulatory Councils and Health Workers, I am confident that the human resource for health challenges will be resolved and the health needs of the population of Sierra Leone will be met.

Zainab Hawa Bangura (Mrs)

Minister of Health and Sanitation

ACKNOWLEDGMENTS

The Human Resources for Health Strategic Plan seeks to address the health sector in a holistic manner. It is evidence-based and has evolved out of a labyrinth of intensive discussions, group work and fact finding exercises.

The Ministry of Health and Sanitation is extremely grateful to its health workers at all levels, civil society groups, the private sector, development partners, faith- based organizations and other stakeholders, without whose efforts the quality of the plan would have been effectively compromised.

The Government appreciates the financial and technical support provided by the World Health Organization (WHO) and European Union (EU) towards the development of this plan. The Ministry also acknowledges the work done by the Directorate of Human Resources for Health under the leadership of the Director, Mr. Prince E.O. Cole, as well as the Human Resources Working Group for their inexorable effort in ensuring the achievement of this significant task.

I wish to further express my sincere appreciation to all those who in diverse ways contributed to the development of this plan. It is my conviction that the strategies delineated in the strategic plan will essentially and effectively address the human resource challenges in the country and will pave the way for the delivery of quality healthcare for all Sierra Leoneans.

JT Kanu

Senior Permanent Secretary

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ACRONYMS

CHASL......	Christian Health Association of Sierra Leone
CHC.....	Community Health Centre
CHO.....	Community Health Officer
CHP.....	Community Health Post
CMO.....	Chief Medical Officer
COMAHS.....	College of Medicine and Allied Health Sciences
CSO.....	Civil Society Organization
DHIS.....	District Health Management Information System
DHS.....	Demographic Health Survey
DMO.....	District Medical Officer
ECOWAS.....	Economic Community of West Africa States
EHO.....	Environmental Health Officer
FBOs.....	Faith Based Organizations
GDP.....	Gross Domestic Product
GoSL.....	Government of Sierra Leone
HIS.....	Health Information System
HMIS.....	Health Management Information System
HR.....	Human Resources
HRD.....	Human Resources Development
HRH.....	Human Resources for Health
HRIS.....	Human Resources Information System
HRMO.....	Human Resources Management Office
HSC.....	Health Service Commission
HSSP.....	Health Sector Strategic Plan
ICT.....	Information Communication Technology
M &E.....	Monitoring & Evaluation
MCH.....	Maternal Child Health
MCHP.....	Maternal Child Health Post
MDGs.....	Millennium Development Goals
MoHS.....	Ministry of Health and Sanitation
NGO.....	Non-Governmental Organization
PHC.....	Primary Health Care
PHU.....	Peripheral Health Units
PSP.....	Public Sector Partnerships
SECHN.....	State Enrolled Community Health Nurse
SLDHS.....	Sierra Leone Demographic Health Survey
SLMDC.....	Sierra Leone Medical and Dental Council
SLNMB.....	Sierra Leone Nurses and Midwifery Board
SWOT.....	Strengths, Weaknesses Opportunities and Threats
TBA.....	Traditional Birth Attendant
ToR.....	Terms of Reference
USL.....	University of Sierra Leone

WAHO..... West Africa Health Organization
WHO..... World Health Organization

I. INTRODUCTION

1. BACKGROUND

The population of Sierra Leone projected from the last census is estimated to be around 6,000,000 with an annual growth rate of 2.1%. The population is predominantly rural with 63% of the population in the rural areas, however there is evidence showing significant rural to urban migration. Freetown is the national capital.

Sierra Leone is situated on the western coast of Africa, bordered by Guinea to the north and northeast, Liberia to the south and southeast, and the Atlantic Ocean to the west. The climate is predominantly tropical with two distinct seasons; the rainy season from May to November, and the dry season which runs from December to May.

Sierra Leone is a developing country, with high morbidity and mortality. Indicators such as infant mortality, under-five mortality and maternal mortality remain significantly high at 89 /1,000, 140 per 1,000 and 857 per 100,000 live births, respectively. Life expectancy at birth male/female is 48/50 years. A lot of work still needs to be done to improve the very high national indicators, which are among the worst in the world.

Most of the diseases are preventable and most deaths are attributed to malaria, diarrhea, acute respiratory infections and neonatal conditions. 61% of the population obtain drinking water from improved sources and only 13% have access to improved, non-shared sanitation facilities. .

The Ministry of Health and Sanitation (MOHS), Sierra Leone is headed by the Minister of Health and Sanitation and two deputy ministers. The organizational structure has two divisions, – the Professional and Administrative divisions. The professional wing is headed by a Chief Medical Officer (CMO) who coordinates eight (8) directorates, namely: Disease Prevention and Control (DPC), Reproductive and Child Heath (RCH), Primary Health Care (PHC), Hospital and Laboratory services, Nursing, Planning and Information (DPI), Drugs and Medical Supplies, and Training. Each directorate is headed by a director who coordinates health programmes and activities under their respective responsibilities.

The Administrative wing is headed by a Permanent Secretary (PS) who coordinates three (3) directorates and a unit which include: Support Services (e.g. stores, transport, facilities etc), Financial Resources, Human Resources for Health (HRH) and Donor and NGO Coordination. The Directorate of Internal Audit reports directly to the Minister of Health and Sanitation.

There are various health care providers in Sierra Leone who include the central government, faith based organizations, local and international NGOs, voluntary organizations, and the private sector. Traditional healers and Traditional Birth Attendants (TBAs) provide a significant amount of health care with TBAs attending to almost 90% of the deliveries at community level.

The health service organization is based on the primary health care concept which was started in the 1980s. The public health delivery system comprises three levels: (a) peripheral health units (community health centres, community health posts, and maternal and child health posts) for first line primary health care; (b) district hospitals for secondary care; and (c) regional/national hospitals for tertiary care.

Government health services are the major sources of health care for the majority of the population, estimated at 70%. The proportion of the budget spent on health was 13.1% in 2010 according to the Economy Watch Web June 2010, which is below the 15% agreed to in the Abuja Declaration. GDP Per Capita has seen an increase from around 600 in 2008 to 808 in 2010.

The health management information system of Sierra Leone has a district-based electronic data management system, known as the District Health Information System (DHIS). It has been developed to integrate and improve the quality and efficiency of data capture, data storage, transfer, analysis and dissemination. This system does not however collect HRH data. HRIS was paper based, but is now being transformed into an electronic information system.

The Health workforce situation:

The Sierra Leone National Health Sector Strategy 2011-2015 states that attracting and retaining health workers is a challenge due to low remuneration, lack of incentives especially for hard to reach areas, poor career development, and cumbersome and bureaucratic recruitment processes that cause unnecessary delays.

The MoHS has a workforce of slightly over 8000. There are high vacancy rates across all disciplines with some as high as 100%. The staff establishment for health professionals is 5036, yet as of October 2011 there were only 1828 in post which gives a 64% vacancy rate. Community Health workers have lower vacancy rates

The HRH Directorate in the MoHS has just 2 staff members with HR qualifications.. The rest are support staff. Their grades are similar to those in the rest of the civil service and they are rotated regularly to other ministries. As a result there might be a problem with institutional memory.

The table below shows the high vacancy rates in the MoHS for both health professionals and administrative staff. Corrective measures will need to be put in place to address this worrisome situation.

Table1.4.1.MoHS Vacancy Levels

Staff Category	Authorised	No. In-post	Vacancy Rate
Specialists (includes Specialists in management position)	75	41	44%
Registrars (All)	70	5	93%
Medical Officers (All)	116	79	32%
House Officer	66	40	39%
Radiographer	16	0	100%
Physiotherapist	13	1	92%
Orthopaedics	52	18	66%
Rehabilitation	285	15	95%
Medical Electronic Engineer	26	0	100%
Medical Equipment Technician/Electrician	96	17	82%
Nutrition & Catering	318	54	83%
M&E	248	14	93%
Environmental Health Aide	540	171	68%
Maternal & Child Health Aide	2640	1892	28%
Nursing Aide/Assistant	1008	1098	+8%
Darkroom Attendant	56	n/a	n/a
Laboratory Aide/Attendant	221	78	65%
Pharmacy	412	197	52%
Medical Laboratory Science	685	183	73%
Refractionist	52	5	90%
Community Health	839	566	33%
Epidemiology	29	1	97%
Health Education	284	5	98%
Environmental (Sanitary) Health	1029	200	81%
Nurses	4536	1746	62%
Midwives	400	76	81%
Senior Ward Sister / Midwifery Officer	100	6	94%

Source: Personnel Unit MoHS October, 2011

The majority of health professionals are in the urban areas and this is not supportive of the Primary Health Care approach. The distribution of community health workers also favors the urban area with 84% of Community Health Officers in the urban areas. Also, 68% of MCH

Aides are in urban areas. There is a critical need for the MoHS to revisit its staffing policies as well as come up with rural retention strategies.

The government owns 7 out of the 12 pre-service training schools; CHASL owns 4 while the private sector owns one. Midwifery is the only nurses' post-basic programme offered while there is no specialist training programme for doctors offered locally. Other programmes like radiotherapy and physiotherapy are also not offered at the local universities, hence the very high vacancy rates. There is no coordination and monitoring mechanism to assess the operations of training schools.

2. SITUATION ANALYSIS

A situation analysis of the health sector Human Resources for Health was conducted and produced in November 2011.The situation analysis presented a picture of the health workforce in Sierra Leone and identified major players in the health sector as well as their mandates. It also provided a base for the development of the HRH Policy and Strategic Plan.

a) Governance for human resources for health

The MoHS is guided by the Sierra Leone NHSSP 2010-2015.The The NHSSP was formulated to give general direction to the health sector as a whole. A MoHS HRH Policy is now in place to give policy direction. At this stage of Strategic Plan development most HRH policies come from the HRMO and the MoHS HR Directorate implements them.

The HR Directorate has significant limitations in both size and technical capacity to manage effectively the human resources functions of the sector. The majority of the staff are general clerks engaged in records management with little exposure to HRH management systems. The Directorate is currently not replicated at district and local level as the function of personnel administration is left to general clerks, who do other tasks over and above human resources.

In May, 2011, the Government of Sierra Leone gazetted the formation of the Sierra Leone Health Service Commission, whose functions include the appointment of professional staff and the determination of remuneration and other conditions of service of the staff. It will also set standards for the training of healthcare providers and ensure compliance with the standards.

These provisions put the responsibility for the training, appointment and management of HRH in the public sector directly in the mandate of the Health Services Commission. The Commission is scheduled to start operating in 2012.

b) Professional regulation

There are only three regulatory bodies in the health sector in Sierra Leone. The main regulatory bodies of the HRH registration process, based on an Act of Parliament, these three bodies are:

- Sierra Leone Medical and Dental Council;
- Sierra Leone Nurses and Midwifery Board;
- Sierra Leone Pharmacy Board

Health professionals are registered at the entry point into service immediately after qualifying and on an annual basis for accreditation and licensing. The professional regulatory bodies are also used for quality assurance and regulation of the practice of health professionals.

c) Production of human resources for health

The Government of Sierra Leone owns most of the training schools through the Ministries of Education, Science and Technology and Health and Sanitation. The Government of Sierra Leones owns 7 of the 12 pre-service training schools with the largest school being the University

of Sierra Leone's College of Medicine and Allied Health Sciences (COMAHS) which covers nine disciplines. The Njala University College in the Southern Region focuses on four disciplines of training. The two universities belong to the Ministry of Education, Science and Technology and from the available evidence there is no discussion of training targets with the MoHS.

Institutions belonging to the CHASL own four of the training institutions, focusing mainly on the state enrolled Community Health Nurse (certificate level). The private for profit sector has one training school that produces the State Enrolled Community Health Nurse.

The highest concentration of schools is in the Western Area, which has five, and each of the other three regions have at least two schools. Midwifery is trained at institutions in the Northern Region and the Western Area.

Without central coordination of the training, each training institution sets its own training targets on the basis of its own internal capacity and therefore there is no unified effort to meet the workforce training needs of the country. However, the Nurses Board has made efforts to standardize the examinations that are set for nursing students and the marking and moderation of these is done by the Board. The curricula of the various fields of study vary from institution to institution according to institutional interests and not the MOHS needs. Training Institutions train the numbers they are capable of handling using their own tutors with minimum or no guidance from the Ministry of Health and Sanitation.

There is no mechanism for assessing physical and professional operations of health training institutions.

Accreditation is expected for health training institutions but many are not accredited. Training institutions are faced with challenges such as inadequate infrastructure, shortage of tutors, demonstration materials, etc

d) Management of human resources for health

In Sierra Leone, on completion of basic training, graduates of the training institutions are not guaranteed employment; they have to compete for whatever posts are vacant. This has led to a growing number of unemployed graduates and some are now finding their way out of the country as they are not guaranteed employment in the country. This however is not consistent with the high vacancy rates that were mentioned earlier even in the entry grades. The challenge that the MoHS faces is that approval is needed from two bodies outside its control, the HRMO and the PSC, in order to hire staff. Even then, the availability of funds is a major factor in filling vacancies as the MoHS has a "paper budget" that does not tally with their HRH needs.

Deployment is done centrally from the national level to the District Health Management Teams and District Hospitals. The Director HRH writes a deployment letter addressed to the new recruit and copied to the head of the health facility, department or unit indicating the date of duty assumption. Induction is managed at the local level by the directorate or department concerned.

All technical grades have a clearly defined career structure whilst the open administrative service is defined in the context of the rest of the civil service.

The open administrative service is in such a position because administrative staff are regularly rotated to and from other ministries. One consequence of this is that institutional memory is easily lost.

The health professionals have their own salary scales (technical) different from those of the support staff, which are much lower. There are few performance incentives in the MoHS. As from March 2010 allowances were absorbed into the basic pay. Basic necessities and amenities in the form of transportation and accommodation remain inadequate especially in primary health units, which compounds the problem of low remuneration. Performance incentives should be based on evaluation of performance, but there is no objective performance appraisal system at the moment.

e) Information and research for human resources for health

The MoHS has a computer based health information system from the CHCs to the national level. The Human Resource Information System (HRIS) has been paper based and is recently established with database software. The system is in its initial phase of implementation and has challenges such as limited internet access; it has not yet been linked to the existing health information system.

There is no human resource research agenda at the moment although there are Human Resources for Health areas that need to be researched in order to guide policy.

f) Partnership for human resource

Currently, interaction is through the health sector steering group and the HRH working group is one of the seven working groups established under the steering group. According to the GOSL Health Compact the HRH working group will drive the HRH agenda of the sector.

Stakeholders in HRH include government ministries, partners, universities, faith based organizations, regulatory bodies and civil society.

SWOT ANALYSIS

It is important at this stage to explore the Strengths and Weaknesses the country has in terms of HRH as well as the Opportunities and Threats before coming up with strategies to address the issues highlighted in the situation analysis.

INTERNAL	**WEAKNESSESS**	**STRENGTHS**
	• Low budget allocation to MoHS • Poor management structures • Limited management and leadership skills • Poor remuneration packages • Poor working environment • Inadequate skilled staff • Poor infrastructure	• Established HRH Directorate • Availability of qualified health workers • Availability of training institutions • Collaboration of MOH and stakeholders
EXTERNAL	**THREATS**	**OPPORTUNITIES**
	• Competition for limited resources • Inadequate government allocation to MoHS • Higher salaries offered by countries in the region • Global economic recession • Unpredictability of donor funding • Inadequate electricity supply	• High priority given to MoHS • Availability of trainable personnel • Political will to support HRH agenda • Availability of partners who support HRH • Peace and stability

3. METHODOLOGY

The HRH strategic plan has been guided by the National Health Sector Strategic Plan and the Draft HRH Policy. The initial draft document was prepared by the MoHS through its HR taskforce established from the Directorate of Human Resources chaired by the Director of Human Resources. The draft was then reviewed and further developed by the HRH working group through a series of meetings and consultations.

The strategic plan was drafted with extensive stakeholder consultation. In the beginning of the process, interviews of key stakeholders were conducted to solicit their views. Two wider stakeholder workshops were conducted; the first one was held for one day to brain storm and come up with key issues to be included in the Strategic Plan. The second stakeholder workshop was a two-day validation workshop. The validation workshop was preceded by a three-day meeting of the HRH working group to prepare the draft document for validation. Finally, a one-day policy dialogue meeting was held before its approval. Dialogue participants were from Ministry of Health and Sanitation, Ministry of Education, Ministry of Finance and Economic Development, Public Service Commission, Human Resource Management Office (HRMO), Public Service Reform Office, Ministry of Local Government, universities and colleges, development partners, and civil society organizations.

In total, the preparation required a series of meetings and the HR taskforce and the working group played a major role, with technical assistance from WHO throughout the whole process.

II. STRATEGIC DIRECTION

1) POLICY CONTEXT

The Strategic Plan has been guided by a number of policies both national and international.

National Health Sector Strategic Plan (NHSSP) 2011-2015

The GoSL in consultation with partners developed a 6 year National Health Sector Strategic Plan which provides the framework for improving the health of the nation. The NHSSP strategic objectives under human resources include the development of an HR Policy and Strategic Plan to guide HR planning and management, enhancing training and management capacity, staff motivation, defined career paths and continuous education as well as the promotion of HRH research.

HRH Policy, November 2011

The HRH Policy gives clear policy direction, which guides the formulation of strategic interventions. The policy spells out the key HRH areas to be focused on as well as the vision, goal and objectives of the policy.

Sierra Leone Health Service Act April 2011

The Act establishes the Health Service Commission which is expected to assist the MoHS in formulating and implementing policies for the delivery of services to the people. These policies include HR policies to do with recruitment of staff, their training and conditions of service.

Sierra Leone Health Compact May 2011

The COMPACT sets out understandings reached between the Government of Sierra Leone and health partners who are signatories to it. It is intended to guide all health partners working in Sierra Leone

Kampala Declaration and Agenda for Global Action March 2008

The Kampala Declaration and Agenda for Global Action adopted by the Global Health Workforce Alliance in 2008 gives countries a roadmap to guide work on HRH over the next decade, translating political will, commitments, leadership and partnership into effective and immediate and sustained actions.

Ouagadougou Declaration April 2008

The Ouagadougou Declaration is a declaration by the member states of the WHO African Region on primary health care and health systems in Africa. The Declaration among other issues urges countries to implement strategies to address HRH needs aimed at better planning, strengthening capacity of health training institutions, management, motivation and retention of health workers.

WHO Code of Practice on International Recruitment of Health Workers May 2010

The Code of Practice encourages Member States of the WHO to establish and promote voluntary principles and practices for the ethical recruitment of health workers.

Abuja Declaration

The Abuja Declaration recommends that Governments allocate a minimum of 15% of the national budget to the health sector. This is an acknowledgement of the critical role the health sector plays in the development of each nation.

2) PURPOSE OF HRH STRATEGIC PLAN

The Human Resources for Health strategic plan guided by the Health Sector Strategic Plan (HSSP) 2010-2015 is formulated to make operational the Human Resources for Health policy. The strategic plan sets a clear road map for the next five years clearly spelling out the goals, objectives and measurable targets as well as monitoring mechanisms.

3) VISION

A functional health workforce that is delivering efficient, high quality health care services that are equitable and accessible for everybody in Sierra Leone.

4) MISSION

The Government of Sierra Leone is committed to providing an enabling environment that will ensure that appropriately skilled and motivated health workers are in place at all levels to achieve the targeted health outcomes.

5) PRINCIPLES and VALUES

The Human Resources for Health Policy upholds the following principles and values:

1. Professional conduct and performance standards oriented towards the patient/client;
2. Maintaining ethical standards and patient/client rights
3. Efficiency and effectiveness in delivery of quality health care services;
4. Transparency and fairness in all principles and practices of human resources management and development;
5. Equality of access to managerial and leadership positions based on merit and relevant qualifications;
6. Recognizing the importance of personal incentives for retention and equitable distribution of health workers;
7. Decentralized implementation of the HR policy and strategy in accordance with the national decentralization strategy;
8. Promoting continuing professional development to boost quality of services;
9. Recognizing the importance of team work and contributions made by different cadres in the sector;
10. Multidisciplinary and multi-sectoral approach to the development of human resources

6) GOAL

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

7) OBJECTIVES

The objectives of the Human Resources for Health policy are, to ensure, within the context of international commitments and national macro-policies, that:

1. Appropriate governance for Human Resources for Health development is strengthened
2. Production (education and training) of Human Resources for Health which addresses the national health needs and meets health personnel requirements of Sierra Leone is improved
3. Management of Human Resources for Health is improved at all levels
4. Information and research on Human Resources for Health are strengthened
5. Partnership among public, private non-profit and for-profit stakeholders in Human Resources for Health is promoted
6. Advocacy and mobilization of resources to support implementation of Human Resources for Health Policy and Strategic Plan is pursued

III. STRATEGIC OBJECTIVES, ACTVITIES AND TARGETS

Strategic Objectives

1. Appropriate leadership and governance for Human Resources for Health development strengthened
2. Training and continuing education of Human Resources for Health
3. Management of Human Resources for Health improved at all levels
4. Information and research on Human Resources for Health strengthened
5. Partnership for Human Resources for Health promoted

1) Strategic Objective One - Appropriate Leadership and Governance for HRH development strengthened

There is need for the MoHS to provide strong leadership to effectively address the HRH crisis. This will require strengthening the leadership capacity in the process of developing, implementing, monitoring and evaluating Human Resources for Health (HRH) policies and plans, norms and standards.

Strengthening of HR management systems and structures is required at all levels. Trained, competent and experienced HR managers shall play a vital role in translating HR policies into action. Leadership skills also need to be developed in managers so as to increase their capacity to coordinate stakeholders and mobilize resources for the HRH agenda.

The Ministry of Health and Sanitation and its partners need to perform continuous evidence-based dialogue on the human resource policy, development, and management. All stakeholders including private for-profit and non-profit should be active role players in the dialogue.

This plan advocates good governance through development of a shared vision, ensuring accountability with respect to planning, implementation, and monitoring of the HRH policy and strategic plan. In addition, it addresses aid-effectiveness and partnerships with development partners and its implication on successful and sustained implementation of the plan.

Policy directions:

1. Top political leaders and partners shall be involved and engaged in the HRH policy processes at national, district and community levels;
2. Structural and technical capacities shall be strengthened for HRH leadership and governance at national and district levels for effective planning, development and management of HRH;
3. Appropriate coordinating mechanisms for relevant stakeholders shall be established/strengthened to ensure harmonized Human Resources for Health planning and budgeting;
4. Formal collaborative and partnership mechanisms shall be established between MoHS and health workers' training institutions (e.g. the Ministry of Education; public and private training institutions and FBOs) to make sure that training outputs match the health sector requirements;
5. Rational and evidence-based health workforce planning guided by workload-based staffing norms;
6. Affirmative action is taken with relation to training and deployment of health workers from and to disadvantaged areas and vulnerable groups.
7. Regulation is strengthened through the establishment and maintenance of standards and rights of health professionals and clients;

a. Roles, mandates and responsibilities of various bodies dealing with regulation, standards and maintenance of ethical conduct shall be clearly defined, and regularly communicated to health workers and the public.
b. Effective legal and monitoring mechanisms for dealing with patients/clients grievances shall be in place including deploying appropriate advocacy to educate patients /clients on their rights.
c. Relevant regulatory bodies shall ensure adherence to and enforcement of ethical professional conduct among health workers through appropriate measures.
d. Empowering and capacitating disciplinary committees and professional councils to handle cases and take appropriate action for misconduct and malpractice.
e. Ensure mandatory re-registration at feasible intervals on the basis of set criteria including continuing professional development.

Strategies

- ✓ Strengthening and using sector coordination mechanism for policy dialogue, and monitoring and evaluation of HRH policies and guidelines;
- ✓ Up-to-date information and effective communication (information sharing) to all relevant stakeholders;
- ✓ Continual leadership capacity building at all levels based on need assessment;
- ✓ Identifying and enhancing opportunities to collaborate with organizations involved in HR production, management and service provision (line ministries/agencies/institutions);
- ✓ Affirmative action in relation to training and deployment of health workers from and to disadvantaged areas and vulnerable groups;

Outputs:

1. HRH working group at national level strengthened and similar structure at district level established and functional by the year 2013
2. Structural and technical capacity of HRH leadership and governance at national and district levels strengthened for effective planning, development and management of HRH
3. Code of conduct and ethics for all health professionals developed and implemented. Conduct of health professionals regularly monitored"
4. Advocacy and mobilization of resources to support implementation of HRH policy and strategic plan

IMPLEMENTATION, MONITORING AND EVALUATION MATRIX

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
Strategic Objective One: Appropriate Leadership and Governance for HRH Development Strengthened					
Output:					
1.1.HRH working group at national level strengthened and similar structure at district level established and functional;	Clear HRH annual plans and budgets				
Activities:					
1.1.1. Clear terms of reference for HRH coordination structure defined and agreed upon	Agreed terms of reference for HRH coordination for all levels	Dec 2012	-	MoHS, CSOs, Partners, Private Sector	GoSL, Partners
1.1.2. Establish and strengthen coordination structures for HRH at district level	Established HRH platform/technical working groups	Jan 2013	10 000	HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners
1.1.3.Develop annual HRH operational work plans	Annual operational plans in place	2012-2016	75 000	HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners
1.1.4. Funding and budgetary provision for HRH are continually reviewed and increased in line with the national budget allocation and the needs of HRH	Resources mobilization plan in place	2012-2016	-	HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners
1.1.5. Regular monitoring of plans and budget	Review report	2012-2016	75 000	HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners
Output:					
1.2.Structural and technical capacity of HRH leadership and governance at national and district levels strengthened for	Fully functional, supported and				

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
effective planning, development and management of HRH	resourced HRH Unit established at all levels				
Activities:					
1.2.1.Expedite the full operationalization of the Health Service Commission	HSC operationalized	December 2012	500 000	GoSL	**GoSL Partners**
1.2.2.Review the structure of MoHS to also reflect critical HR units at district level	Reviewed and implemented structure	March 2013	10 000	HSC MoHS	GoSL Partners
1.2.3.Strengthen capacity of MoHS HRH Directorate and district level based on defined needs	Capacity building embarked on	2012 -2016	60 000	HSC MoHS	GoSL Partners
1.2.4.Strengthen collaboration and coordination of the HSC,HRMO and PSC to ensure integration through regular meetings and information sharing	Number of regular meetings conducted	2012 -2016	10 000	HSC MoHS	GoSL Partners
1.2.5.Enhancing leadership and management capacity at all levels	Number of department heads trained in leadership and management	2012 -2016	120 000	HSC MoHS	GoSL Partners
1.2.6.Improving supportive supervision systems including mentoring, counseling and coaching, behaviour change programmes	No of managers trained in supportive supervision	2012 -2016	30 000	HSC MoHS	GoSL Partners
Output:					
1.3.Professional conduct and ethics of all health professionals developed, implemented, strengthened and regularly monitored	Staff behavior reflects established standards and ethics				
Activities:					
1.3.1.Facilitate the establishment and functionality of regulatory councils/bodies for all health professionals	▪ Functional regulatory councils/bodies in place ▪ Enactment of legislation	Dec 2013	10 000	HSC MoHS	GoSL& Partners

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
1.3.2. Review and refine the functions, mandates and responsibilities of regulatory and professional bodies in collaboration with relevant stakeholders	Roles defined	Dec 2012	30 000	HSC MoHS	GoSL & Partners
1.3.3. Develop code of conduct for all health professionals and communicate to stakeholders including patients	Developed, implemented and disseminated code of conduct	June 2013	35 000	HSC MoHS	GoSL & Partners
1.3.4.Facilitate collaboration between all health service providers and professional councils	Collaboration mechanism established	January 2013	10 000	HSC, MoHS HRHWG	Partners
Output:					
1.4.Advocacy and mobilization of resources to support implementation of HRH policy and strategic plan					
Activities:					
1.4.1. Conduct resource mobilization activities such as advocacy sessions	▪ Proportion of fund mobilized	2012-2016		HSC MoHS, Partners	GoSL& Partners

2. Strategic Objective Two: Training and Continuing Education of Human Resources for Health

This section of the plan covers pre-service, post-basic, post graduate and in-service training. It is critical to put in place an aggressive strategy to increase output from training schools in order to meet the outstanding gaps of health workforce requirement. The required Human Resources for Health needs to be carefully planned and projected using available scientific planning tools. Development of a well costed training plan for the required HR shall be a priority activity. The training plan shall focus on pre-service, post-basic and post-graduate training to ensure availability of the required skill mix. Curricula for training institutions will need to be standardized to include essential elements of competence that support effective service delivery.

The strategies outlined in this section of the plan seek to address planning and coordination of pre-service, post-basic, post-graduate training and professional development opportunities locally and abroad. The strategies also encourage infrastructural development, standardization of curricula and the establishment of minimum standards for training institutions.

Policy directions:

1. A costed medium and long-term national training plan for the different cadres, based on training needs assessment and training policy aspects, shall be developed and implemented;
2. Education and training, including pre-service, in-service and postgraduate training programmes shall be community-oriented, competence-based, cost-effective, relevant and responsive to national health needs.
3. Ensure that resources are allocated to clinical facilities to ensure that the training needs are supported
4. There shall be collaborative efforts and decisions regarding training programmes and curricula between MoHS and other key partners/ministries (Ministry of Education, professional councils, Public Service Commission, Human Resource Management Office (HRMO), Ministry of Finance and Economic Development (MoFED), local governments and the private for profit and not for profit sector etc) to ensure relevance of training programmes to national health needs.
5. Ensure continuing performance improvement through setting and maintaining high professional standards, peer review mechanisms, supportive supervision and other ways of promoting a culture of continuing professional development.
6. Promote and support career progression through structured training opportunities and objective performance appraisal methods.
7. Continuing education/in-service training opportunities shall be coordinated and regulated to avoid gaps, redundancies and disruption of health services.
8. Ensure that quality standards are established and maintained in the training and practice of health workers, through a variety of appropriate measures in consultation with relevant stakeholders in training and regulation.
9. Effective accreditation bodies and mechanisms shall be established, strengthened and maintained to regulate health training courses, staffs and curricula.

Strategies:

- ✓ Rationalize and align supply of health workforce to the priorities of the health sector
- ✓ Creation of an advisory body (Health Training Coordinating Committee-HTCC) by MOHS to allow for all relevant stakeholders to be involved in the process of developing and implementing the national training plan.
- ✓ Advocating and supporting the approval of the Sierra Leone Postgraduate Colleges of Health Specialties Act and its implementation.
- ✓ Assuring quality in pre-service, in-service and postgraduate training institutions and programmes
- ✓ Strengthening health workforce training capacity and output based on service requirements
- ✓ Expanding the use of technology in providing education and training to employees such as the use of ICT and e-learning in inter-professional education
- ✓ Fostering and assisting in the harmonization of education, accreditation and regulation
- ✓ Involving private sector providers in health-worker training

Outputs:

1. National HRH training plan developed and implemented with expanding training output
2. Training institutions strengthened/established, supported and maintained to increase training capacity
3. Pre-service, post-basic & postgraduate trainings of health workers supported to increase production
4. Continuing professional development/ in-service training and career development provided and improved
5. Accreditation of training institutions and quality assurance of training and practice of health workers established, supported & maintained

IMPLEMENTATION, MONITORING AND EVALUATION MATRIX

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
Strategic Objective 2: Training and Continuing Education of Human Resources for Health					
Output:					
2.1. National HRH Training Plan developed and implemented with expanding training output	Approved HRH Training Plan				
Activities:					
2.1.1. Establish a technical working group to allow for inclusion of relevant stakeholders in decisions regarding the National Training Plan	Approved ToR for technical working group	Sep 2012	2000	HSC, MOHS, training Institutions, relevant Gov & private institutions	GoSL & Partners
2.1.2. Conduct a training needs analysis to determine skills gaps and publication of regular updated HRH country requirements	Up-dated training needs report	Dec 2012	30 000	HSC, MOHS, training Institutions, relevant Gov & private institutions	GoSL & Partners
2.1.3. Write a mid-term and long term National HRH Training Plan	Approved national training plan	March 2013	15000	HSC, MOHS, training Institutions, relevant Gov & private institutions	GoSL & Partners
2.1.4. Financial resources mobilized to implement the approved training plan	Proportion of financial resources mobilized	2013-2016		HSC, MOHS, training Institutions, relevant Gov & private institutions	GoSL & Partners
Output:					
2.2. Training institutions strengthened/established, supported and maintained to increase training capacity	Training capacity of training institutions to respond to the country demand				
2.2.1. Mechanisms of cooperation established	Cooperation framework in	2013	1 000	HSC, MoHS,	GoSL&

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
and strengthened between training institutions and the health sector to implement the National Training Plan	place			MEYS, Partners	Partners
2.2.2. Collaborate and support training institutions in designating, training needs; constructing, rehabilitating and equipping to cater for the training needs of the sector	Institutions constructed Institutions rehabilitated Institutions equipped	2012-2016	Construction and rehabilitation costs	Local Authorities, MoHS, Partners	GoSL& Partners
2.2.3. Provide/facilitate adequate teaching and learning materials, and financial support for training institutions	Adequate teaching and learning materials in institutions	2012-2016	Costs for materials	Local Authorities, MoHS, Partners	GoSL& Partners
2.2.4. Collaborate with training institutions to review and update curricula for training programmes in line with international standards and national requirements	Curricula reviewed	2012-2016	60 000 Cost of Meetings	MoHS, All training Institutions, Professional Councils, MEYS	GoSL& Partners
2.2.5. The Sierra Leone Postgraduate Colleges of Health Specialties Act is enacted and established	Enacted Postgraduate Act	Dec 2012	5000	MoHS	GoSL& Partners
Output:					
2.3. Pre-service, post -basic & postgraduate trainings of health workers supported to increase production					
Activities:					
2.3.1. Develop relevant pre-service training programmes for the production of adequate numbers based on national priorities	Pre-service training programmes	2013	10000	HSC, MOHS, training Institutions, relevant Gov & private institutions	GoSL & Partners
Activities:					
2.3.2. Re-orient postgraduate and post-basic training programmes to the priority needs of	Re-oriented postgraduate and post-basic training	Dec 2012	10000	HSC, MOHS, training Institutions, relevant Gov &	GoSL & Partners

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
the country	programmes			private institutions	
2.3.3. Strengthen the planning, implementation, management, and monitoring of scholarships for the HRH	Scholarships system in place	2012-2016	5000	HSC, MOHS, training Institutions, relevant Gov & private institutions	GoSL & Partners
2.3.4. Provide/support in-service, post-basic and postgraduate trainings	Number of trained health workers	2012-2016	9,859,490	HSC, MOHS, training Institutions, relevant Gov & private institutions	GoSL & Partners
2.4. Continuing professional development/ in-service training provided					
Activities:					
2.4.1. Work with the collaborating institutions to develop programmes for continuous professional development	MoU with collaborating institutions	2012	5000	HSC, MOHS, training Institutions, relevant Gov & private institutions	GoSL & Partners
2.4.3. System developed to identify the training activity requirements of all health facilities and allocate the appropriate budget to fund these activities	Approved training requirement	2012-2016	10000	HSC, MOHS, training Institutions, relevant Gov & private institutions	GoSL & Partners
2.4.3. Collaborate with professional councils to standardize and accredit continuing professional development/ in-service training for health professionals	Standardized continuing professional development/ in-service training	2012-2016	15000	HSC, MOHS, training Institutions, relevant Gov & private institutions	GoSL & Partners
2.4.4. Conduct relevant in-service training for all categories of healthcare staff	Proportion of health workers enrolled in in-service training	2012-2016	4,172,000	HSC, MOHS, training Institutions, relevant Gov & private institutions	GoSL & Partners
Output:					
2.5. Accreditation of training institutions and quality assurance of training and practice of health workers established,	Quality standards in place				

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
supported & maintained					
Activities:					
2.5.1. Advocate for and support training institutions to implement and monitor their standards based on the accreditation framework	Capacity of training institutions to monitor their standards	2012-2016	5 000	Training Schools, MoHS, professional councils	GoSL Partners
2.5.2. System developed to ensure the existence, strengthening and maintenance of appropriate professional bodies to deliver accreditation and set standard s	System in place	2013	10 000	Training Schools, MoHS, professional councils	GoSL Partners
2.5.3. Accreditation of training institutions (public and private) facilitated	Proportion of training institutions accredited	2012-2016	25000	Training Schools, MoHS, professional councils	GoSL Partners
2.5.4. Promote the establishment of communication and cooperation with international institutions active in quality assurance in order to get technical and other support	Established network with international institutions for quality	2012-2016	5 000	Training Schools, MoHS, professional councils	GoSL Partners

3. Strategic Objective Three: Management of Human Resources for Health improved at all levels

There is need for clear polices in the hiring, deployment and management of staff. The focus of this Strategic Objective is to promote effective management of the health workforce and create a conducive workplace environment using recruitment, distribution, motivation and retention strategies

It is the MoHS's mandate to ensure the availability of the right staff in the right quantity at the right place at the right time at all times. There is need to review and improve current staffing norms to match workload and disease burden. The health sector also needs a well organized system of equitable deployment of staff and appropriate skills mix. The target numbers, skills mix and the range of competencies must be based on service demands and epidemiological priorities.

In this plan recruitment policies will be reviewed to identify bottlenecks, and solutions to reduce bureaucracy will be adopted. A coordinated deployment policy will be put in place.

To improve performance the plan advocates for implementation of a performance appraisal system and implementation of evidence–based retention strategies including different incentive packages for remote rural areas and institutionalization of a health, safety and welfare programme.

Policy directions:

1. Recruitment and deployment systems at central and district levels shall be established/ strengthened and harmonized to ensure an equitable deployment in the health sector.
2. Mechanisms to facilitate career progression, promotions and mobility of the health workforce across the entire health sector with particular attention to rural and remote areas shall be developed and implemented.
3. Deployment guidelines shall be developed and implemented to ensure an equitable distribution of well trained health workers in all health facilities in both urban and rural settings.
4. Evidence-based staff retention mechanisms/strategies shall be in place for essential categories of health cadres in services and areas of highest need.
5. Remuneration and promotion shall be based on merit, fair job evaluations, and regular benchmarking with similar work in both public and private sectors.
6. Objective individual performance assessment methods shall be introduced and used in the staff appraisal process to improve performance
7. Quality assurance mechanisms shall be strengthened to monitor and enhance professional performance in the health sector
8. Adequate safety measures shall be provided for health workers in the work place at all times

Strategies

- ✓ Creating and using task force by MoHS to develop a streamlined process to facilitate the immediate appointment of newly qualified healthcare workers into the MoHS payroll;
- ✓ Introducing innovative, responsive, fair, consistent recruitment and selection policies and practices to promote effective and efficient utilization of health workers to ensure a qualified and diverse workforce;

- ✓ Introducing ways to optimize the working and living environment for health employees;
- ✓ Encouraging, executing and maintaining effective retention mechanisms so as to attract diasporans; Increase of salaries and the introduction of special allowance for staff in special circumstances;
- ✓ Regular monitoring and supportive supervision of health staff by the Human Resources Directorate;
- ✓ Decentralizing HRH functions to districts;

Outputs:

1. Availability and equitable distribution of health workers across the country ensured
2. Guidelines for clear career progression of staff developed and implemented
3. Staff confidence maintained and secured by the implementation of the improved performance/ contract based appraisal system
4. Staff attraction and retention strategy developed and implemented
5. Trained and qualified staff recruited, well remunerated and supervised
6. Health safety and protective measures introduced and maintained

IMPLEMENTATION, MONITORING AND EVALUATION MATRIX

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
Strategic Objective Three: Management of Human Resources for Health improved at all levels					
Output:					
3.1. Availability and equitable distribution of health workers across the country ensured	No. of health facilities fulfilling the minimum requirements for staff as prescribed by the basic package				
Activities:					
3.1.1. Review existing recruitment procedures to make them decentralized.	Revised recruitment procedures	Jan 2013	10 000	HSC, MoHS CSOs, Partners, Private Sector, HRMO	GoSL, Partners
3.1.2.Develop deployment guidelines for different cadres of health workers which includes affirmative action in favor of disadvantaged areas in collaboration with stakeholders	Deployment guidelines in place	Dec 2012	10 000	HSC, MoHS CSOs, Partners, Private Sector, HRMO	GoSL, Partners
3.1.3. Carry out workload analysis and review staffing norms at all levels using scientifically proven model	workload analysis report and staffing guidelines	Dec 2012	25 000	HSC, MoHS CSOs, Partners, Private Sector,	GoSL, Partners
Output:					
3.2. Guidelines for clear career progression of staff developed and implemented	Availability of developed and utilized guidelines				
Activities:					
3.2.1 Review advancement procedure for all staff categories and communicate appropriately.	Approved guidelines for career progression	Dec 2013	45 000	HSC, MoHS HRMO	GoSL, Partners

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
3.2.2 Develop and implement the scheme of service to ensure clear career path for each cadre of health worker.	Approved scheme of service in place	August 2012	55 000	HSC, MoHS HRMO	GoSL, Partners
3.2.3 Conduct orientation of staff on HRH documents.	No. of personnel aware of the content of career progression guidelines	Dec 2013	130 000	HSC, MoHS HRMO	GoSL, Partners
Output:					
3.3. Staff confidence maintained and secured by implementation of an improved performance/ contract based appraisal system	Reduced incidence of staff grievance, complaints and strikes Percent of customer survey respondents rating overall satisfaction with services as good or better				
Activities:					
3.3.1. Develop and implement a performance appraisal system for all health workers.	Availability of improved tool to carry out staff appraisal	Jan 2013	25 000	HSC, MoHS HRMO	GoSL, Partners
3.3.2. Strengthening the performance management system through training and other mechanisms	Number of managers trained	2013-2016	40 000	HSC, MoHS	GoSL, Partners
3.4.3. Design mechanism to reward staff for good performance and vice versa.	Staff reward mechanism in place	Dec 2013	10 000	HSC, MoHS HRMO	GoSL, Partners
Output:					
3.4. Staff attraction and retention strategy developed and implemented.	Reduced staff turnover in the health sector				
Activities:					
3.4.1. Develop and implement a clear staff retention strategy including retention	Approved retention package	May 2013	10 000	HSC, MoHS CSOs, Partners,	GoSL, Partners

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
package for hard-to-reach areas				Private Sector, HRMO	
3.4.2. Facilitate the introduction of community service for graduates trained with public support (by signing contract).	Proportion of graduates trained with public support who signed for community service	Dec 2012	5 000	HSC, MoHS CSOs, Partners, Private Sector, HRMO	GoSL, Partners
3.4.3.Lobbying for improved staff welfare and amenities including housing and recreation facilities	Proportion of health facilities with plan for staff housing units and recreation facilities	2012-2016	5 000	HSC, MoHS CSOs, Partners, Private Sector, HRMO	GoSL, Partners
3.4.4.Institutionalize employment of health workers to international posts	Employment guidelines for international postings in place	2014		HSC, MoHS	
Output:					
3.5. Trained and qualified staff recruited, well remunerated and supervised	Proportion of appropriately qualified staff employed and deployed				
Activities:					
3.5.1. Review and implement staffing norms	Staffing norms in place	May 2013	25 000	HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners
3.5.2. Negotiate regionally competitive salary scales for all health workers.	Improved staff salary conditions	Nov 2012	-	HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners
3.5.3. Design and implement clear recruitment procedure for all health workers.	Recruitment procedure in place	Dec 2012	10000	HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners
3.5.4. Recruiting additional health workforce in line with identified gaps at all levels	Number of health workers recruited	2012-2014		HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners
3.5.5. Developing a mechanism for deployment	Deployment mechanism for FBO in place	Dec 2012	5000	HSC, MoHS CSOs, Partners,	GoSL, Partners

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
of staff to faith based health services				Private Sector	
3.5.6. Plan for and conduct regular supportive supervision to all cadres of staff regularly each year.	Number of supportive supervisions conducted	2012-2014	60000	HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners
3.5.7. Conduct induction/orientation for new health workers	Induction/ Orientation conducted by Dec 2016	2012-2016	50 000	MoHS HSC	GoSL& Partners
3.1.4. Staff remunerated	Proportion of staff adequately remunerated	2012-2016	345,396,811	HSC, MoHS, HRMO	GoSL& Partners
Output:					
3.6. Occupational safety promoted and protective measures introduced and maintained	Percentage reduction of workplace accidents				
Activities:					
3.6.1. Develop and implement health and safety workplace policy at all levels.	Health and safety workplace policy in place	2013	10000	HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners
3.6.2 Train all health workers in occupational health and safety measures.	Proportion of health workers trained	2012-2014	70000	HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners
3.6.3. Procure and distribute protective equipment and clothing to all government health institutions.	Proportion of health facilities with protective equipment and clothing at all levels	2013	5000	HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners
3.6.4 Monitor regularly to ensure that protective equipment and clothing are in place and in use at all times.	Proportion of health facilities monitored	2012-2014	15000	HSC, MoHS CSOs, Partners, Private Sector	GoSL, Partners

4. Strategic Objective Four: Information and Research on Human Resources for Health strengthened

The focus is on contributing to the generation of human resources intelligence, through HR information systems and research including the establishment of national observatories for evidence based policy implementation, monitoring and evaluation. The country will need current, accurate data which give managers information needed to asses HR problems, plan effective interventions and evaluate these interventions. The strength of an HRIS depends on its ability to generate information that is accurate, timely and adaptable to address new HRH issues. The country will strive to develop an HRH Observatory to ensure that HRH information is disseminated and shared with relevant stakeholders and to monitor progress at country level. Proper coordination and definition of HR research priorities are required to improve sharing of information and utilization of results.

Kampala Declaration 11 urges countries to create health workforce information systems, to improve research and to develop capacity for data management in order to institutionalize evidence based decision making and enhance shared learning."

The strategies outlined in this section of the strategic plan are therefore aimed at developing and strengthening the HRIS networking of existing data collection systems as well as ensuring that information is shared with relevant stakeholders.

Policy directions:

1. Human Resources for Health information and data systems across relevant MDAs are linked/ coordinated to produce an improved, expanded and integrated computerized Human Resources for Health information system.
2. HRIS shall be strengthened to enhance data collection, storage, analysis and utilization.
3. Statistics, guides and norms shall be developed to foster efficient management, monitoring and evaluation of the health workforce within the national health service
4. National health workforce observatories shall be created and operationalized;
5. Specific attention and resources shall be devoted to the utilization of research findings to inform and influence Human Resources for Health policymaking and practice;
6. The early introduction of information and communication technology developments shall be promoted
7. Mechanisms shall be established, strengthened and maintained for effective monitoring and dissemination of information related to recruitment, attrition and retention, disaggregated to reveal the equity and access picture across the various districts

Strategies

- ✓ Strengthening of the HRH information system in the context of Health Information Systems
- ✓ Strengthening data use for monitoring and evaluation of HRH development
- ✓ Strengthening of HRH capacity to develop and manage an integrated HRIS.
- ✓ Using appropriate communication and monitoring mechanisms for dissemination of HRH information.
- ✓ Establishing prioritized human resources research as a tool for improving health staff management in the public and private sector

Outputs:

1. An integrated HRIS as part of the HMIS is in place by the year 2013
2. Regular and up-dated HR inventory and statistical reports produced for decision making
3. Establish and strengthen human resources research to enable evidence-based decisions for the improvement of service delivery

IMPLEMENTATION, MONITORING AND EVALUATION MATRIX

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
Strategic Objective Four: Information and Research on Human Resources for Health strengthened					
Output:					
4.1. An integrated HRIS as part of the HMIS is in place by the year 2013	Functional HRIS integrated with HMIS				
Activities:					
4.1.1.Establish HRIS software	HRIS software installed	Jan 2012	80000	HSC, MoHS	GoSL& Partners
4.1.2.Build ICT infrastructure and install internet connectivity	HRH networked with ICT infrastructure	Dec 2013	150000	HSC, MoHS	GoSL& Partners
4.1.3.Integrate HRIS with HMIS	Mechanism in place to integrate the systems	Dec 2014	50000	HSC, MoHS	GoSL& Partners
4.1.4. Train ICT workers/system administrators	Number of trained ICT workers/system administrators	2012-2016	15000	HSC, MoHS, Partners	GoSL& Partners
4.1.5.Conduct regular system maintenance	Functional HRIS/no interruption	2012-2016	45000	HSC, MoHS, Partners	GoSL& Partners
Output:					
4.2. Regular and up-dated HR inventory and statistical reports produced for decision making	Up-dated HR information used in decision making				
Activities:					
4.2.1 Provide regular training to HR staff (data entry clerks, managers, analysts, and decision-makers to ensure system sustainability.	Number of trained HR staff	2012-2016	25000	HSC, MoHS, Partners	GoSL& Partners

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
4.2.2 Institutionalized HRH data collection, compilation, interpretation and analysis, and use of reports for evidence-based decision making.	Quarterly HRH report Up-to-date HRH Database	2012-2016	30000	HSC, MoHS,	GoSL& Partners
4.2.3. Establish HRH Observatory.	HRH Observatory in place	2012-2016	5000	HSC, MoHS,	GoSL& Partners
4.2.4 .Establish appropriate communication and monitoring mechanism for dissemination of HRH information.	Regular performance review and report	2012-2016	8000	HSC, MoHS, Partners	GoSL& Partners
Output:					
4.3 Establish and strengthen Human Resources Research to enable evidence-based decision making for the improvement of service delivery	Research results contributed to improved service delivery				
Activities:					
4.3.1. Establish functional partnership with research institutions and other relevant stakeholders.	ToR and MoU agreed with partners for HRH research	Dec 2012	8000	HSC, MoHS, Partners	GoSL& Partners
4.3.2. Develop a prioritized national HRH Research Agenda.	List of research agenda	March 2013	5000	HSC, MoHS, Partners	GoSL& Partners
4.3.3 .Conduct/commission and publish research both at national and district level.	Proportion of research conducted based on the agreed list of agenda	2013-2016	613,433	HSC, MoHS, Partners	GoSL& Partners
4.3.4.Advocacy and resource mobilization for HRH research agenda	Proportion of fund mobilized for the proposed agenda	2012-2016	-	HSC, MoHS, Partners	GoSL& Partners
4.3.5.Disseminate and utilize research findings to inform HRH policy and implementation	Proportion of research results disseminated to users	2013-2016	15000	HSC, MoHS, Partners	GoSL& Partners

5. **Strategic Objective Five: Partnership for Human Resources for Health promoted**

Development of strategic partnerships among all stakeholders is vital. It seeks to deliver health services through formal and informal linkages among partners, professional associations and the private sector. Kampala Declarations 1,2 and 5 acknowledge the importance of partnerships in HRH.

This plan seeks to strengthen existing collaboration mechanisms.

Policy directions:

1. HRH coordination mechanisms shall be expanded and strengthened to engage all relevant stakeholders and development partners to facilitate policy dialogue for the HRH agenda at national and international levels such as the African platform on human resources for health.
2. Close collaboration and coordination with key stakeholders and development partners in the planning, training and management of health workers in the health sector.
3. Compliance with global, regional and sub-regional institutional arrangements and forums that promote Human Resources for Health standards and professionalism; whilst making sure that national relevance and needs take precedence.

Strategies

- ✓ Promoting and implementing the country compact for better sector coordination for HRH partnership
- ✓ Strengthening appropriate public and private partnerships to ensure coherence and support for the Human Resources for Health plans
- ✓ Ensuring mechanism is in place for training and deployment of health workers in both private and public institutions
- ✓ Establishing mechanisms for information sharing with relevant stakeholders including private sector
- ✓ Addressing the implications arising from uncontrolled commercialization including the absence of regulation, which negatively impacts on access to and equity of health services.
- ✓ Facilitating south-south and north-south technical cooperation on HRH.

Outputs:

1. Improved capacity of MOHS to negotiate, align and harmonize stakeholder activities
2. Collaboration among public and private providers of health services and other HRH stakeholders fostered.

IMPLEMENTATION, MONITORING AND EVALUATION MATRIX

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
Strategic Objective Five: Partnership for Human Resources for Health promoted					
Output:					
5.1. Improved capacity of MOHS to negotiate, align and harmonize stakeholder activities	Functional HRH coordination mechanisms at all levels				
Activities:					
5.1.1.Expanded and functional HRH coordination mechanisms in place at all levels	Regular reports on the monitoring of implementation of HRH policy and plan	Dec 2012	10 000	HSC MoHS	GoSL & Partners
5.1.2.Establish platforms for strategic HRH partnerships with regional and international groupings	# of international and regional HRH Forums established	2013 - 2016	80 000 Costs Of meetings	HSC MoHS GoSL	GoSL Partners
Output:					
5.2. Public-private partnership strengthened	Staff trained in negotiation skills				
Activities:					
5.2.1 Public-private partnership strengthened	Joint partnership forum organized	2012-2016	75000	HSC, MoHS, Partners	GoSL& Partners
5.2.2 Mapping and analysis of existing partners with interest in the HRH agenda.	Quarterly HRH report	Dec 2012	30000	HSC, MoHS, Partners	GoSL& Partners
5.2.3. Develop an agreement between the private partners and government on training of health workers; and adequate use and	HRH Observatory in place	March 2013	5000	HSC, MoHS,	GoSL& Partners

Narrative Summary	Indicators	Time Frame	Estimated Costs (USD)	Responsible Body	Funding Partner
retention of trained personnel					

IV. MONITORING AND EVALUATION OF THE HRH STRATEGIC PLAN

All HRH stakeholders will be involved in the implementation of the Plan. The MoHS will take a leading role. Advocacy will be carried out to mobilize all stakeholders. The HR Directorate and the HR working group will oversee the implementation of the Plan. The various departments in the Ministry will develop their HR Action Plans from the objectives of the Strategic Plan.

The M&E functions will be will be conducted at national, regional and district level. At national level the HR Directorate will lead the process. At regional and district levels the regional health team and district health team should likewise lead the process. Annual progress review meetings will be held with representation from all levels. Reports will be produced and forwarded to the HRWG.

V. BUDGET SUMMARY HRH STRATEGIC PLAN 2012-2016

The budget estimate for the implementation of the strategic plan is US$361,522,692.00. The majority of the budget is for the HR management which includes salary and other benefits. The cost for training and continuing education will be revised when the training plan is prepared. The estimate unit costs were derived from the average costs from other African countries which used the WHO Costing Tool to arrive at these costs. The unit costs are as shown in Table 3 below

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Table 2: Summary of Estimate Budget HRH Strategic Plan 2012-2016

	Narrative Summary	Cost (US$)
Strategic Objective 1	Appropriate Leadership and Governance for HRH Development Strengthened	975,000.00
1.1	HRH working group at national level strengthened and similar structure at district level established and functional;	160,000.00
1.2	Structural and technical capacity of HRH leadership and governance at national and district levels strengthened for effective planning, development and management of HRH	730,000.00
1.3	Professional conduct and ethics of all health professionals developed, implemented, strengthened and regularly monitored	85,000.00
1.4	Advocacy and mobilization of resources to support implementation of HRH policy and strategic plan	-
Strategic Objective 2	Training and Continuing Education of Human Resources for Health	14,248,881.00
2.1	Mid-term and long-term National HRH Training Plan developed and implemented	47,000.00
2.2	Training institutions developed, supported and maintained to increase training capacity	66,000.00

2.3	Pre-service, post -basic & postgraduate trainings of health workers supported to increase production	9,884,490.00
2.4	Continuing professional development/ in-service training provided	4,201,391.00
2.5	Accreditation of training institutions and quality assurance of training and practice of health workers established, supported & maintained	50,000.00
Strategic Objective 3	Management of Human Resources for Health improved at all levels	346,018,811.00
3.1	Availability and equitable distribution of health workers across the country ensured	45,000.00
3.2	Guidelines for clear career progression of staff developed and implemented	230,000.00
3.3	Staff confidence maintained and secured by implementation of an improved performance/ contract based appraisal system	75,000.00
3.4	Staff attraction and retention strategy developed and implemented.	20,000.00
3.5	Trained and qualified staff recruited, well remunerated and supervised	345,548,811.00
3.6	Occupational safety promoted and protective measures introduced and maintained	100,000.00
Strategic Objective 4	Information and Research on Human Resources for Health strengthened	1,034,433.00
4.1	An integrated HRIS as part of the HMIS is in place by the year 2013	340,000.00
4.2	Regular and up-dated HR inventory and statistical reports produced for decision making	68,000.00
4.3	Establish and strengthen Human Resources Research to enable evidence-based decision making for the improvement of service delivery	626,433.00
Strategic Objective 5	Partnership for Human Resources for Health promoted	280,000.00
5.1	Improved capacity of MOHS to negotiate, align and harmonize stakeholder activities	170,000.00
5.2	Public-private partnership strengthened	110,000'00
	Grand total	361,522,692.00

Table 3: Activity Costs HRH Strategic Plan

ACTIVITY	UNIT COSTS-US
Workshops	150 per person per day including accommodation and allowances
Meetings	1 000 per one day workshop of 40 people
Technical Assistance	25 000

Training	
Medical Doctor	100 000
Dentist	90 000
Registered General Nurse	30 000
Pharmacist	35 000
Pharmacy Technician	25 000
EHO	25 000
Radiographers	40 000
Physiotherapists	40 000
Lab Technologist	25 000
Med Lab Scientist	20 000
Nurse Midwives	10 000
SCMLT	8 000
SECHN	10 000
BSc Nursing	10 000
Masters Public Health	10 000
Masters Environmental Health	24 000
MCH Aides	4 000
Community Health Officer	8 000

Annex 1: Training plan for the year 2012-2016. (Note this plan will be replaced by the short and long-term training plan)

Activities	Time Frame	Res	Outputs	Indicators	Estimated Costs	Funding Partner
1.Train 125 medical doctors at 25 per year	2012-2016	HSC, MoHS COMAHS MEYS	Medical Doctors trained by Dec 2016	Number trained	$11.5m Training materials Tuition fees	GoSL& partners
2.Train **30** dentists at **6** per year	2012-2016	MoHS HSC	Dentists trained by Dec 2016	Number trained	$2.7m -Training materials Tuition fees	GoSL& partners
3.Train **600** Registered Nurses at **120** per year	2012-2016	MoHS, Training Schools	Registered Nurses trained by Dec 2016	Number trained	$18m Training materials Tuition fees	GoSL& partners
4. Train 600 midwives at 60 per year	2012-2016	MoHS, Training Schools	Midwives trained by Dec 2016	Number Trained	$6m Training materials Tuition fees	GoSL& partners
5.Train 75 Pediatric nurses at **15** per year	2012-2016	MoHS, Training Schools	Pediatric Nurses trained by Dec 2016	Number Trained	$2.25m Training materials Tuition fees	GoSL& partners
6.Train 35 Nurse Anesthetists at 7 per year	2012-2016	MoHS, Training Schools	Nurse Anesthetists trained by Dec 2012	Number Trained	$350 000 Training materials	GoSL& partners
7.Train 50 Pre-Operative Nurses at 10 per year	2012-2016	MoHS, Training Schools	Pre-Operative Nurses trained by Dec 2016	Number Trained	$500 000 Training materials	GoSL& partners
8.Train 30 Ophthalmic Nurses at 6 per year	2012-2016	MoHS, Training Schools	Ophthalmic Nurses trained by Dec 2016	Number Trained	$300 000 Training materials	GoSL& partners
9.Train 20 ICU Nurses at 4 per year	2012-2016	MoHS, Training Schools	ICU Nurses trained by Dec 2016	Number Trained	$200 000 Training materials	GoSL& partners
10.Train 1500 SECHNs at 300 per year	2012-2016	MoHS, Training Schools	SECHNs trained by Dec 2016	Number Trained	$15m Training materials	GoSL& partners
11.Train **375** Environmental Health Officers G4 at **75** per year	2012-2016	MoHS, Training Schools	EHO G4 trained by Dec 2016	Number Trained	$11.25m Training materials Tuition Fees	GoSL& partners
12.Train **500** Environmental Health Officers G5 at **100** per year	2012-2016	MoHS, Training Schools	EHO G5 trained by Dec 2016	Number Trained	$12.5m Training materials, Tuition Fees	GoSL& partners

Activities	Time Frame	Res	Outputs	Indicators	Estimated Costs	Funding Partner
13.Train 270 Environmental Health Officers G6 at 54 per year	2012-2016	MoHS, Training Schools	EHO G6 trained by Dec 2016	Number Trained	$1.05m Training materials Tuition fees	GoSL & partners
14.Train **60** Pharmacists at **12** per year	2012-2016	MoHS, Training Schools	Pharmacists trained by Dec 2016	Number Trained	$2.1mTraining materials Tuition fees	GoSL& partners
15.Train **300 P**harmacy Technicians at **60** per year	2012-2016	MoHS, Training Schools	Pharmacy Technicians trained by Dec 20116	Number Trained	$7.5m Training materials Tuition fees	GoSL, partners
16.Train 150 Laboratory Technicians at intake of **30** per year	2012-2016	MoHS Professional councils	Lab Technicians trained by Dec 2016	Number Trained	$3.75m Training materials Tuition fees	GoSL, Partners
17.Train 1500 MCH Aides at 300 per year	2012-2016	MoHS, Training Schools	MCH Aides trained by Dec 2016	Number Trained	$6m Training materials	GoSL partners
18.Train 300 Community Health Officers at 60 per year	2012-2016	MoHS, Training Schools	CHOs trained by Dec 2016	Number Trained	$2.4m Training materials	GoSL partners
19.Train 300 Community Health Assistancts at 60 per year	2012-2016	MoHS, Training Schools	CHAs trained by Dec 2016	Number Trained	$1.2m Training materials	GoSL partners
20.Sponsor **10** doctors to undertake specialist training in Radiology at **2** per year	2012-2016	MoHS COMAHS	Radiologists trained by Dec 2016	Number Trained	$3m Tuition Fees	GoSL & partners
21.Sponsor **8** doctors to undertake specialist training in Nephrology at **2** per year	2012-2016	MoHS COMAHS	Nephrologists trained by Dec 2016	Number Trained	$240 000 Tuition Fees	GoSL, partners
22.Sponsor **5** doctors to undertake specialist training in Hematology at **1** per year	2012-2016	MoHS COMAHS	Hematologists trained by Dec 2016	Number Trained	$150 000 Tuition Fees	GoSL, partners
23. Sponsor **8** doctors to undertake specialist training in Neurology @ intake of **2** per year	2012-2016	MoHS COMAHS	Neurologists trained by Dec 2016	Number Trained	$240 000 Tuition Fees	GoSL, partners
24.Sponsor **12** doctors to undertake specialist training in Psychiatry @ intake of **3** per year	2012-2016	MoHS COMAHS	Psychiatrists trained by Dec 2016	Number Trained	$360 000 Tuition Fees	GoSL partners

Activities	Time Frame	Res	Outputs	Indicators	Estimated Costs	Funding Partner
25.Sponsor **20** doctors to undertake specialist training in Neuro-Surgery @ intake of **4** per year	2012-2016	MoHS COMAHS	Neuro-Surgeons trained by Dec 2016	Number Trained	$600 000 Tuition Fees	GoSL partners
26.Sponsor **25** doctors to undertake specialist training in Medicine @ intake of **5** per year	2012-2016	MoHS COMAHS	Physicians trained by Dec 2016	Number Trained	$750 000 Tuition Fees	GoSL partners
27.Sponsor **25** doctors to undertake specialist training in Gen Surgery @ intake of **5** per year	2012-2016	MoHS COMAHS	Surgeons trained by Dec 2016	Number Trained	$750 000 Tuition Fees	GoSL partners
28. Sponsor **5** doctors to undertake specialist training in Dermatology @ intake of **1** per year	2012-2016	MoHS COMAHS	Dermatologists trained by 2016	Number Trained	$150 000 Tuition Fees	GoSL partners
29.Sponsor **8** doctors to undertake specialist training in Ear Nose and Throat Surgery @ **2** per annum	2012-2016	MoHS COMAHS	Ear Nose Throat Surgeons trained by Dec 2016	Number Trained	$240 000 Tuition Fees	GoSL partners
30.Sponsor **25** doctors to undertake specialist training in Paediatrics @ **5** per annum	2012-2016	MoHS COMAHS	Paediatricians trained by Dec 2016	Number Trained	$750 000 Tuition Fees	GoSL partners
31.Sponsor **25** doctors to undertake specialist training in Obstetrics and Gynaecology @ intake of **5** per year	2012-2016	MoHS COMAHS	Obstetrics and Gynecologists trained by Dec 2016	Number Trained	$750 000 Tuition Fees	GoSL partners
32.Sponsor 2**5** doctors to undertake specialist training in Ophthalmology @ intake of **5** per year	2012-2016	MoHS COMAHS	Ophthalmologists trained by Dec 2016	Number Trained	$510 000 Tuition Fees	GoSL partners
33.Sponsor 12doctors to undertake specialist training in Anesthetics @ intake of **3** per year	2012-2016	MoHS COMAHS	Anesthetists trained by Dec 2016	Number Trained	$350 000 Tuition Fees	GoSL partners
34.Sponsor **30** health workers to undertake Masters in Public Health @ intake of **6** per year	2012-2016	MoHS COMAS	Public Health Specialists trained by Dec 2016	Number Trained	$300 000 Tuition Fees	GoSL partners