MINISTRY OF HEALTH & SANITATION

SIERRA LEONE HUMAN RESOURCE FOR HEALTH DEVELOPMENT PLAN 2006-2010.

OCTOBER, 2006.

ABBREVIATIONS

B Pharm	-	Bachelor of pharmacy
Bsc.	-	Bachelor of Science
CHO	-	Community Health Officer
CHC	-	Community Health Centre
CHP	-	Community Health Post
CMS	-	Central Medical Stores
CHDN's HOSP	-	Children's Hospital
CONN. HOSP.	-	Connaught Hospital
DHMT	-	District Health Management Team
DIST. HOSP	-	District Hospital
DFID	-	Department for International Development
DMO	-	District Medical Officer
DPC	-	Disease Prevention and Control
EDC	-	Environmental health
EHO	-	Environmental Health Officer
HIV/AIDS	-	Human Immune Virus/Acquire Immune Deficiency Syndrome
HR	-	Human Resources
HRIS	-	Human Resources Information System
HRM	-	Human Resources Management
H/Ed.	-	Health Education
HND	-	Higher Teacher Certificate
IMCI	-	Integrated Management of Childhood Infection
MAL	-	Malaria
MBBS	-	Bachelor of Medicine, Bachelor of Surgery
MCH AIDES	-	Maternal and Child Health Aides
MCHP	-	Maternal and child Health Post
MCH/EPI	-	Maternal and Child Health/Expanded Programme on Immunization
MO	-	Medical officer
MD	-	Medical Doctor
MOEST	-	Ministry of Education Science and Technology
MOHS	-	Ministry of Health and Sanitation
MOLGRD	-	Ministry of Local government and Rural Development
MSc.	-	Master of Science
MTEF	-	Medium Term Expenditure Framework
SCM	-	State Certified Midwife
SECHN	-	State Enrolled Community Health Nurses
SRN	-	State Registered Nurse
SOS	-	Scheme of Service
PCM HOSP	-	Prince's Christian Maternity Hospital
PHC	-	Primary Health Care
PHU	-	Primary Health Unit
PMO	-	Personnel management Office
PROV Hosp.	-	Provincial Hospital

PSC	-	Public Service Commission
RH/FP	-	Reproductive Health and Family Planning
RHS	-	Reproductive Health Services
ONCHO	-	Onchocerciasis Programme
TBA	-	Traditional Birth Attendant

PREFACE

The shortfall of Health Personnel continues to represent one of the major constraints to the development of health services and access to basic health care in Sierra Leone. This is against a background of increased demands for health care from various stakeholders, a shrinking budget against high expectations from the public for quality health care. This health human resource plan seeks to chart the course for a coherent resolution of major human resources problems and puts in place a framework to facilitate decision making in the human resources arena.

The plan contains an analysis of the current situation with a focus on the distribution of Health Personnel, the current stock, wastage, outputs from training schools, dropout rates and human resources policies currently obtained in the Ministry of Health and Sanitation. It also projects future requirements based on the recommended establishment. A supply driven projection is also made to show the feasibility of the current training capacity meeting staff requirements in five years.

The Ministry of Health and Sanitation is committed to implementing all the strategies in the plan in order to improve quality of health care and access to basic health services. All partners are encouraged to participate in the implementation of this plan.

The Ministry of Health and Sanitation wishes to recognise the European Union, World Bank, African Development Bank, WHO and a host of other development partners, for their financial assistance and especially the EU Human Resource Consultant Mr. S.T Lungu for his valuable technical assistance. The Human Resources division of the Ministry of Health and Sanitation should be praised for initiating and seeing the process through. The Ministry of Health and Sanitation officials all worked tirelessly to provide ideas and suggestions to produce the plan.

Mrs. Abator Thomas.
Hon. Minister of Health and Sanitation.

EXECUTIVE SUMMARY

This document is a Human Resources Development Plan for (2004 – 2008) for the health sector in Sierra Leone. The process adopted was to consult widely with responsible individuals from different types of health care. This was done through a series of workshops in December 2004. This document is the result.

SITUATION

The key finding in the situational analysis is that the numbers of health providers employed by MOHS in rural arrears, PHUs are very few and that it takes long to get trained officers on government payroll. These, CHO and SECHN are the crucial personnel to deliver Primary Health Care. Most CHOs are not joining MOHS services because of delays in absorption and poor incentives which include salaries. The progress in training MCH aids has been successful in getting health providers in rural areas. Even so, there are still more of them required.

Both the MOHS and other providers are short of trained staff. This situation is worse in the nursing and clinical areas. The plan has determined broad training requirements for various jobs in each group (clinical, nursing, pharmacy and PHC), but these are dependent on a number of key strategy actions and will need refining during the plan period.

Training types needed have been prioritized based on vacancies, the need to ensure primary health care is delivered in rural areas and the impact training one group of people would have on another.

THE PLAN

The guiding principle in constructing the Health Sector Human Resource Development Plan is that it should support the implementation of the National Health Policy. The overall purpose to be achieved during the plan period is therefore: *Adequate and equitable distribution of appropriately trained and effective staff to provide planned health services in Sierra Leone.*

To achieve this purpose, the following outputs need to be achieved during the plan period:

1. The capacity to maintain staffing levels in line with service needs.
2. Training and development in line with staffing requirements as specified in the Human Resource Development Plan
3. Effective and targeted staff retention measures developed
4. Effective personnel management systems established
5. The capacity to manage staff in place at decentralised levels established

There is no immediate solution to the current staffing problems. However, the successful achievement of these outputs should ensure that the problems are resolved as soon as possible within the current human and financial resource constraints. Moreover, with robust human resource planning, management and development systems in place, the risk of a similar staffing crisis in the future will be significantly reduced.

LOGICAL FRAMEWORK FOR HEALTH SECTOR HUMAN RESOURCE DEVELOPMENT PLAN 2004-2008

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Goal Efficient and effective delivery of appropriate and high quality preventive and curative health care services to a larger proportion of Sierra Leone's population	1 Quality care provided in PHUs and district, and tertiary hospitals 2. Rational allocation and transparent use of resources	MOHS Health Management Information System	1 Security and stability 2. Economic productivity
Purpose Adequate and equitable distribution of appropriately trained and effective staff to provide planned health services in Sierra Leone.	1. Vacancies for all cadres filled 2. Resignations reduced 3. All DMO posts filled	1. HR information system 2. MOHS Health Management Information System	1. Resourcing of health services increases 2. No restriction to absorption of health personnel

Health Sector Human Resources Development Plan -2004-2008

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Outputs 1. Capacity to maintain staffing levels in line with service needs	1.1 National HR policy in place by 2005 1.2 Health Sector HR Co-ordinating body strengthened 1.3 Effective national HRIS established and used by 2005 1.4 Staffing standards revised for major staff groups by 2005 1.5 Costed national health human resource plan covering all health providers updated annually 1.6 Planning carried out at decentralised levels according to national guidelines.	1.1 Health Sector HR Co-ordinating 1.2 Sample survey of employers	1. Rigid labour legislation and regulation does not inhibit the deployment and management of trained staff, especially in decentralised health services 2. Minimal political interference at local and national level in staffing matters 3. Value of public sector salaries does not decrease in real terms 4. No marked increase in attrition amongst employees
2. Training and development in line with staffing requirements as specified in the Human Resource plan	2.1 Increased basic training output for specified groups and start the training of Laboratory Technicians, Medical assistants and community Health Assistants. 2.2 Improving quality of training: teaching methods and facilities 2.3 Effective co-ordination mechanism in place between training providers and service providers/ employers 2.4 Career management system linked to organisational requirements in place 2.5 50% of managers attended management development programme by 2006	2.1 Annual reports of training Institutions 2.2 Quality of training survey & reports of professional regulatory councils 2.3-2.5 Health Sector HR Co-ordinating body's annual report	5. Changing health service needs enumerated throughout plan period to enable staffing requirements to be derived 6. Sufficient supply of complementary inputs to enable staff to function effectively 7. Sustained acceptance of priorities in the Human Resource plan by government and other stakeholders 8. Authority to plan and manage workforce devolved to decentralised levels by 3rd year of plan

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
3. Effective and targeted staff retention measures developed	3.1 Strategies for increasing retention of EHO, SECHN & CHO in rural areas in place by 2006 3.2 Strategies for increasing retention of doctors at district level by 2006	3.1-2 Health Sector HR Co-ordinating body's annual report	
4. Capacity to manage staff at decentralised levels established	4.1 One manager per Institution trained in HRM by 2006	4.1 Health Sector HR Co-ordinating body's annual report	
5. Effective management of the change process (the public sector and health reforms) implemented	5.1 Employee relations systems improved 5.2 Detailed costed plan to manage transition complete 6 months before the appointed start date 5.3 No major Industrial action	5.1 Sample survey of employers 5.2 Health Sector HR Co-ordinating body's annual report 5.3 Press reports	

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Activities [see activities listed by Output on separate Gantt chart]	Inputs 1. Staff salaries 2. Training (recurrent costs) 3. Equipment and refurbishment costs 4. Technical assistance for systems and training development 5. Funding for Health Sector HR Co-ordinating body		1. Successful resolution of discrepancies between MTEF approach to funding staff recruitment.

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CHAPTER 1

INTRODUCTION

1.1 Purpose and use of the plan

The purpose of the health human resource (HR) plan is to outline the way in which health personnel in the health sector will be trained and employed over the next 5 years in order to support the implementation of the National Health Policy. The plan also indicates how human resources planning and management systems will be developed in line with changing health service structure.

The plan indicates how the overall health policies of the country will be resolved in so far as they affect health workers. The plan will also take into account the economic and social policies and context within which the health system operates.

The plan will describe in general terms the work to be done by each category of health workers, their employers, grades, sex and location. Projections will be made to help in crafting a strategy to meet staff requirements wherever appropriate, specific targets will be defined and underlying assumptions or rationale explained.

Inevitably the plan is in outline form. It is not possible to anticipate every detail or work out all actions that will have to be undertaken by those responsible for the operation of the health system. Annual work plans will be made at the sector level and by individual institution in line with the budget cycle.

1.2 Specific use of the plan

The specific uses to which the plan will be put include:-

- Providing a framework within which consistent decisions regarding the supply, utilization and deployment of appropriately trained staff may be made;

- Indicating where resources are inadequate or likely to become inadequate unless corrective action is taken;

- Identifying needs for external assistance in Human Resource planning and production and so assisting the health authorities in formulating proposals to be put to external funding agencies;

- Providing a realistic indication to staff and potential entrants to the service of their likely career paths and prospects of advancement.

1.3 Process of developing the plan

The process of developing the plan involved two key steps.

1. Compilation of the Situational Analysis.

The situational analysis was done through the use of the baseline information. Several methods were used to compile baseline information

i Human Resource Data (HRD) Survey – this survey was conducted between March and July 2004 in all health institutions (public and private).

ii Data from Stakeholders- Various stakeholders in the different sections provided data for personnel in their sections during the consultative workshops.

2. Consultation Workshops

Two workshops were held for the Northern Province and Western area and Southern and Eastern provinces with the following objectives:-

- to explain the approach and process for producing the plan;
- to present the human resources situational analysis in Sierra Leone; and
- to develop human resource development strategies in the sector and prioritize them

1.4 Development of Situational Analysis:-

The main aim for developing the situational analysis was to define the status of HR management systems and policies, the quantity and quality of health personnel in Sierra Leone. The following information was collected and used in developing the situational analysis:-

- Contextual information;
- Human Resource Policies;
- Number of personnel of each health institution;
- Number of personnel at each level of Health Care delivery
- Jobs in the health sector.

- Number of operational facilities and population for each district;
- Distribution of personnel between rural/urban, service level and functional areas;
- Age and sex distribution of personnel; and
- Basic training intakes, and outputs

An attempt was made to collect data on staff wastage but it was difficult to get information as staff records are not properly kept in MOHS.

Data Collection

Data was collected from various sources. The major source was a special survey - Human Resource Development Survey conducted by the HR division with the help of monitoring and evaluation officers from the directorate of Planning and Information - The figures presented in this plan therefore represent the staffing situation as of July 2004, unless otherwise stated. The principal method for collecting data was questionnaire supported by interviews. Literature review was also used to understand current HR policies and context. The data enumerators had to visit each facility which was known by the DHMT.

Data Analysis/Synthesis and Interpretation

A supply driven stock and flow approach was used to make Human Resource projections. Computers were also used to synthesize data in numbers and percentages in the tables presented in the plan. Human Resource knowledge and skills were used in interpreting HR implications of tabulated data.

Limitations

There were several problems encountered during data collection exercise. In most cases dates of birth, appointment, and wastage could not be ascertained as DHMTs do not keep staff files. Other inaccuracies were due to staff being on leave or in rural inaccessible areas.

1.5 Consultation process

Using the situational analysis prepared as starting point, two consultation workshops were conducted. One workshop was for Western area and Northern province while the other was for the Eastern and Southern provinces. The participants of each workshop were drawn from key stakeholders in the main staffing groups- hospital and laboratory, nursing and primary health care. At each workshop issues arising from the situational analysis were reviewed. Prioritized strategies were developed for inclusion in the plan. The workshops identified

other issues that needed to be addressed in the plan and they have since been included in the plan.

1.6 Prioritization

Though there is room for many developments and improvements in the human resources situation, through the process of consultation the key strategies in the plan have been prioritized. Prioritization has been based on the following principles: strategies that are both achievable, affordable and have the greatest impact on improving the delivery of health services in accordance with the draft national health policy framework and national recovery strategy.

1.7 Plan Review

The plan can not be regarded as remaining static over the whole 5 year period. Inevitably economic and political events will occur during the next five years, and indeed developments in the field of health care, cannot be predicated with certainty. Therefore, an annual review of the plan should be undertaken to revise and extend the plan forward. In this way it becomes a regularly up-dated 5-year 'rolling plan.

CHAPTER 2

THE CONTEXT

The human resource situation in the health sector will be affected both by the wider environment-economic factors, the broader government and civil service policies and the labour market-and by the policies of the health sector itself. This section provides background information of the wider environment and the current draft health policy framework of the Ministry of Health and Sanitation (MOHS).

2.1 Policy Environment

2.1.1 Pubic service Environment

Strategic policy making in HR is the prerogative of the Establishment Secretary who reports to the Secretary to the President, through the Secretary to Cabinet who is head of the civil service. Line ministries, such as the MOHS are responsible for implementation.

The Establishment Secretary is responsible for creating and controlling staff establishments and positions, recruitments, appointments,discipline and retirements.

The Public Service Commission (PSC) is responsible for conducting recruitment and promotion interviews.

2.1.2 Structural Adjustment

Structural adjustment measures seek to permit renewed, or accelerated economic development by correcting 'structural disequilibrium in foreign and public balances. These measures have been embraced and are being implemented by the Sierra Leone government. Among other things, these measures in Sierra Leone have been employed to eliminate distortions and inefficiency of public services. In the Sierra Leone Public Service, one of the objectives is to control growth in employment of junior cadres. A government circular to this effect was issued in 1992. Growth is however allowed in priority cadres.

2.1.3 Public Service Reform

The public service is earmarked to undergo major reforms to reduce inefficiencies and strengthen its capacity. This will see changes in human resource management structure and practice. The main features of these reforms include:-

- Management and functional reviews of key ministries which include Ministry of Health and Sanitation;
- Strengthening the capacity of the cabinet secretariat;
- Introduction of new personnel management regulations;
- Weekend training seminars for middle and senior level civil servants;
- Resuscitation of the Civil Service Training College;
- Computerisation of civil service personnel records for staff rationalisation;
- Review of central policy-making and coordination machinery in government of Sierra Leone; and
- Conversion of Establishment Secretary's Office into new Personnel Management Office (PMO).

2.1.4 Functional Review

The functional review report is a review of the Ministry of Health and Sanitation to promote good governance in the public service in order to restore efficiency and increase its capacity for the delivery of services to the population. The report reviews the functions, structures and management arrangements at the Ministry of Health and Sanitation and makes recommendations to improve the situation.

The main actors include DFID and the Public Service Reforms Unit. Recommendations include among others:-

- Appropriate grades and classification of senior management post in Ministry of Health and Sanitation should be sought from establishment secretary for the directorate structure;
- The work of the HR Directorate including the current activities of the Personnel Unit should come under the direct control of the Director of Support Services
- Schemes of service in the health sector should be reviewed to ensure they continue to meet the needs of the cadres concerned;
- All professional, administrative and clerical staff should be provided with job descriptions;
- Meetings of former Top Management Team should be activated and the name of the committee should be Technical Management Committee;
- The ministry should develop a personnel policy to cover its own staff with the assistance of Establishment Secretary's Office;
- The anomaly in grading whereby public health inspectors are graded at the same level as senior drivers and caretakers should be normalised ;
- The Ministry of Health and Sanitation should be included in any Records Management Programme initiated by the Public Service Reform Unit;
- The Ministry should ensure accurate information about the number; category and location of staff working for it;
- The personnel unit should undertake a monthly reconciliation exercise between the staff list and the payroll

- The Ministry of Finance should issue a directive to the Ministry of Health and Sanitation and Establishment Secretary Office for the possibility of exceeding the agreed authorized establishment;
- Two middle grade officers should be assigned to the personnel unit to strengthen its capacity and provide additional administrative support;
- The Ministry should be earmarked for job inspection;
- The personnel unit should prepare a manpower plan for Ministry of Health and Sanitation;
- A training needs assessment should be carried out; and
- The Ministry of Health and Sanitation should co-operate in full with the Tertiary Education Commission of training institutions.

The MOHS is currently implementing these recommendations.

2.1.5 Local Government Decentralisation

There is a Local Government Decentralization Act published on 4th March, 2004, as a supplement to the Sierra Leone Government Gazette volume CXXXIV, No. 15. The act paves the way for devolution of authority and responsibility from the centre to district councils. There is a section which gives human resource management responsibilities to Local Government Service Commission to be set up.

The Local Government Service commission will, "after consulting the Public Service Commission (Section 38 a) develop policy guidelines for recruitment, training, promotion, remuneration and discipline of local council…." "Set staff performance standards, develop professional standards, assist in carrying out organisational and job analysis for local councils, after consulting the Public Service Commission, develop common schemes of service and performance appraisal systems and promote equal opportunity practices (Section 38 b, c, d, e and f)."

Functions to be devolved to Local Councils from Ministry of Health and Sanitation (MOHS) are Registration of Births and Deaths, Public Health Information and Education, Primary Health care, Secondary Health Care, maintenance of non-technical equipment, Facilities Management, procurement of Equipment and Medicines (Third Schedule : Functions to be devolved to Local Councils).

Local government elections have been held and district and town councillors elected.

2.1.6 Hospital Boards

The MOHS sponsored a bill which is now an Act requiring that each hospital should have a Hospital Management Board. The Hospital Boards Act was published on 6th November, 2003 as a supplement to the Sierra Leone Gazette

Volume CXXXIV, No. 53. These boards will have authority over the running of hospitals and in consequence over HR issues.

The Hospital Board will " appoint such staff as it considers necessary for efficient performance of its functions; and the staff shall be appointed on such terms and conditions as the Board may determine" (Section 19).

Hospital Boards have been instituted for government hospitals across the country.

2.1.7 Merger of the Paramedical School and School of Hygiene

The two schools merged to become the Community Health Training School so as to engender economies of scale through maximum utilisation of existing synergies. This is expected to produce efficient use of resources and improved quality of the training output. It is envisaged that the output of Community Health Officers (CHO) will increase in the coming years.

2.1.8 Tertiary Education Commission

The government of Sierra Leone has established a tertiary education commission through the Tertiary Education Commission Act, 2001 which was published in the supplement to the Sierra Leone Gazette Volume CXXXII, No. 25 dated 10th May 2001.

The main function of the commission is to over see the development of tertiary education in Sierra Leone. This means all basic and post-basic health personnel training institutions will be under this commission which is under the Ministry of Education Science and Technology (MOEST). This means the Ministry of Health and Sanitation will have to define a new relationship with MOEST and the tertiary education commission if its training requirements are to be met.

2. 1.9 Activity Based Budgeting/Medium Term Expenditure Framework

The Ministry of finance is responsible for budget reforms using activity based budgeting framework – an initiative designed to improve the use of scarce resources. All activities are costed – including the staffing costs and then incorporated into annual budgets. There is no budgeting for vacant positions. As far as the activity based budgeting is concerned the establishment is the sum of the posts that are filled.

2.1 Health Sector

2.2.1 National Health Policy

The overall goal of the health sector is to maintain and improve the health of all persons resident within the country with equity.

The main strategy for health care delivery in Sierra Leone is Primary Health Care (PHC) Services with effective referral links and prevention as they are cost effective. As such the delivery of health care is based on the following principles:-

- The development of an integrated health system with inter-linked roles for primary, secondary and tertiary level of care;
- The strengthening of the referral system between the levels of specialization, and appropriate feedback between health care professionals;
- The involvement of communities in decisions about health;
- Collaboration between sectors;
- An emphasis on preventive strategies; and
- Empowerment of communities for promotive Health Care.

The health policy framework enunciates the following activities for HR in the health sector:-

- Development of Human Resource plan;
- Development of strategies to reduce rural mal-distribution of health personnel across the country;
- Improvement in the terms and conditions of service for health personnel in Ministry of Health and Sanitation
- Development of a common code of practice for the employment of both Non governmental organisation staff and government staff receiving incentive payments from non governmental organisations.
- Encouragement of Sierra Leone health professionals currently working outside the health sector or outside the country to rejoin;
- Filling of health positions with expatriates in the medium term;
- Strengthening of professional councils;

- Conducting a training needs analysis of the health sector's, first the training needs of primary health care will be given priority; and
- In-country training institutions are to be given priority in the plans of the health sector

2.2 National Health Human Resource Policy

The public service has human resources guidelines applicable to all government employees. However, as yet, there is no national health human resources policy document.

2.3 Organizational arrangement for human resources planning

The Human Resource Management and Development section of Ministry of Health and Sanitation is responsible for the development of the Human Resource Plan. The plan will be approved by Ministry of Health and Sanitation.

2.4 The Social-economic context

The following assumptions have been made in the development of this Human Resource plan:

2.4.1 Demography and Health Status

It is assumed the population to be served will grow at 2.6% through out the planning period. Other demographic indicators at the time of Plan development include:

Birth Rate 45 births/ 1,000 Population
Death Rate 19 deaths / 1,000 Population
Infant mortality 170 / 1,000 Live births
Under 5 Mortality 286 / 1,000
Maternal Mortality 1,800/100,000
Life Expectancy 37 years
HIV/AIDS prevalence 4.9%: Rural 4.0% Freetown 6.l%.

Source: National Recovery Strategy, Sierra Leone, 2002-2003

2.4.2 Economic Growth and Funding of Government Health Services

It is assumed that the country's economy will grow by 5.4% through out the planning period. It is further assumed that the proportion of the national budget devoted to health care will grow annually. Table 1 below shows the MOHS human resources budget growing for the period 2004- 2006.

Table 1 - MOHS HUMAN RESOURCES BUDGET ALLOCATION FOR 2004-2006

Programme	Actual annual allocation 2004 (le'000')	% Allocation	Indicative Estimates 2005 Le('000')	% Estimates	Indicative Estimates 2006 (Le'000')	% Estimate
Human Resources Management	2,033,238	5.6	2,419,466	5.8	2,737,987	5.8

Source: MOHS Annual Health Sector Review (2003) and Medium Term Rolling Plan (2004-2006)

2.5 Distribution of Health Facilities by Controlling Agent, Type and Location

Table 2 shows the total number of Health facilities by controlling agent, type and district in Sierra Leone. Most primary health facilities are in districts. Western Area which is largely urban has more hospitals providing both secondary and tertiary care.

Table 2 - NUMBER OF HEALTH FACILITIES IN SIERRA LEONE

DISTRICT	CHC	CHP	MCHP	Mission	Other	Total	Gover nment	Defence & Education	Mission Hospital	Private & industrial Hospital	Total
Bo	21	16	45	2	3	87	1	-	1	1	2
Bombali	16	15	35	2	6	74	1	-	2	-	3
Bonthe	9	10	15	2	3	39	1	-	1	1	2
Kailahun	17	34	7	1	4	63	1	1	1	-	3
Kambia	7	19	9	3	2	41	1	-	1	-	2
Kenema	16	35	34	2	4	91	1	1	2	-	4
Koinadugu	6	15	30	-	1	52	1	-	-	-	1
Kono	10	25	26	2	2	65	1	-	-	-	1
Moyamba	21	29	45	2	7	104	1	-	1	-	2
Port Loko	19	22	33	2	3	79	2	-	2	-	4
Pujehun	12	11	23	-	1	47	1	-	-	-	1
Tonkolili	5	11	53	1	1	71	1	-	2	-	3
Rural W/Area	9	5	9	-	4	27	2	1	1	-	4
Urban W/Area	25	9	17	-	22	73	22	6	2	78	72
TOTAL	193	256	381	19	63	913	36	9	16	80	104

Source: Revised National PHC Handbook, June 2004

2.6 Distribution of Functioning and Non-functioning Facilities by Location

Table 3 below shows facilities that are operational and those that are not functioning. The non-functional facilities were damaged during the war of the 90's. These facilities present additional staff requirements. Moyamba district has more non functioning facilities followed by Port Loko and Kanema respectively. Western Area has more functioning facilities.

Table 3 - NUMBER OF FUNCTIONAL AND NON-FUNCTIONAL FACILITIES

DISTRICT	FUNCTIONAL FACILITIES	NON-FUNCTIONAL FACILITIES
Bo	79	10
Bombali	74	6
Bonthe	36	6
Kailahun	47	18
Kambia	33	7
Kenema	59	25
Koinadugu	35	18
Kono	56	12
Moyamba	78	28
Port Loko	59	38
Pujehun	42	6
Tonkolili	69	5
Rural Western Area	27	2
Urban Western Area	75	4
TOTAL	738	156

Source: Revised National PHC Handbook, June 2004

CHAPTER 3

The current stock of the health workforce

3.1 Overview

This section starts by describing the different types of health personnel. The distribution of workforce by employer is given, followed by staffing strengths compared with the number of standard staffing. The distribution of staff is then reviewed by: level of care, age, sex, public or private, geographical location including urban/rural split. Next the workforce flows are reviewed. Finally HR management, policies and systems are considered, namely performance management, personnel and career management.

The total size of trained health personnel in the health sector is estimated at 3,736 giving a trained health worker: population ratio of approximately 1:1,705.

Additionally there are Traditional Birth Attendants who are either without or with minimal training input who provide reproductive health services at community level.

In addition there are many voluntary personnel who also provide health services of some kind. The number of volunteer personnel in MOHS is estimated at 975. Although they do not have salary costs, there are resource implications for equipment. The largest provider of health services is the Ministry of Health and Sanitation, followed by non-governmental organizations.

3.2 Non-salaried Health Care Providers

A substantial number of non-salaried health personnel are used in the health sector. There are Traditional Birth Attendants in all the districts in the country providing an average 85% of midwifery services to rural communities. The provision of reproductive health services by TBAs faces some problems which include inadequate delivery kits, transport and communication mechanisms for referral of patients. There are many untrained TBAs in all the districts. Non- governmental organisations and development partners such as DFID and UNICEF have provided funding for TBA training in the past. There are currently arguments against the existence of TBA as their impact on the reduction of infant and maternal mortality is said be negative. Table 4 provides numbers of TBAs in 8 districts in Sierra Leone.

Table 4 - NUMBER OF TRADITIONAL BIRTH ATTENDANTS IN SIERRA LEONE

DISTRICT	No. OF UNTRAINED TBAs	No. OF TRAINED TBAs	TOTAL
BOMBALI	608	1031	1639
KAMBIA	603	519	1122
KENEMA	1182	585	1767
KONO	1146	431	1577
KOINADUGU	403	489	892
MOYAMBA	318	1097	1415
PUJEHUN	471	440	911
TONKOLILI	411	989	1400

Source: MOHS HRD Survey, July 2004

Volunteer personnel provide a range of health services across the country health systems. Table 5 below shows distribution of volunteer staff by level of care and type of work. Most volunteer staff work as Nursing Aides and most volunteers are in district hospitals seconded by provincial facilities. There are also a good number of volunteer vaccinators at PHU level and at the district hospital level.

Table 5 - DISTRIBUTION OF VOLUNTEER STAFF IN MOHS BY CADRE AND BY LEVEL OF CARE

CADRE	TOTAL	CONN HOSP.	KISSY MENTAL HOSP	CHC	CHP	MCHP	CMS	DISTRICT	PROVINCE	OTHER H/S
Cleaner	**54**	12	0	6	1	3	0	16	14	2
Cloakroom Attendant.	**4**	0	0	0	0	0	0	4	0	0
Cook	**21**	0	0	0	0	0	0	15	6	0
Driver	**27**	2	0	0	0	0	16	4	2	4
Driver's Mate	**9**	0	0	0	0	0	0	3	0	6
Assistant Electrician	**3**	0	0	0	0	0	0	1	2	0
Filing Clerk	**1**	0	0	0	0	0	0	0	0	1
Lab Assistant	**7**	0	0	0	0	0	0	3	4	0
Lab Technician	**4**	0	4	0	0	0	0	0	0	0
Labourer	**20**	3	0	2	1	1	6	5	0	3
Laundress/Laundryman	**11**	0	0	0	0	0	0	4	7	0
Mason	**1**	0	0	0	0	0	1	0	0	0
Mechanic	**4**	0	0	0	0	0	4	0	0	0
Nursing Aide	**373**	0	0	9	0	0	0	255	102	14
Porter	**42**	8	0	7	1	2	0	12	10	2
Public Health Aide	**5**	0	0	1	0	0	0	4	0	0
Records Clerk	**27**	0	1	7	1	0	1	6	10	1
SECHN	**1**	0	0	1	0	0	0	0	0	0
Secretary/Typist	**1**	0	0	0	0	0	0	0	0	1
Security/Watchman	**34**	0	0	8	1	0	0	9	16	0
Store Clerk	**1**	0	0	0	0	0	1	0	0	0
Vaccinator	**328**	0	0	74	71	71	0	99	0	12
X-Ray Assistant	**1**	0	0	0	0	0	0	0	1	0
Total	**975**									

Source: MOHS HRD Survey, July 2004

3.3 Employers of Health Personnel

Most health personnel are employed by the Public Health sector (MOHS, Army, Police) but others are employed by non- public health sector (e.g. Christian Mission, Muslim Mission) or other non-governmental agencies, and some categories of health personnel are self employed (private practitioners). Table 6 below captures the number of personnel employed in the sector by health service provider.

Table 6 – DISTRIBUTION OF HEALTH PERSONNEL BY PROVIDER

CADRE	TOTAL	PRIVATE/ PROFIT	MUSLIM MISSION	CHRISTIAN MISSION	EU	NGO	UN	MOHS	POLICE	ARMY	PRISON	FOURAH BAY COLLEGE
Anaesthetist	**1**	0	0	0	0	0	0	1	0	0	0	0
Biochemist	**5**	0	0	0	0	0	0	5	0	0	0	0
Cardiologist	**1**	0	0	0	0	0	0	1	0	0	0	0
Chiropodist	**1**	0	0	0	0	0	0	1	0	0	0	0
CHO	**170**	10	0	0	0	22	0	132	1	0	0	0
Dental Surgeon	**5**	0	0	0	0	0	0	2	0	0	0	0
Dental Technician	**6**	0	0	0	0	0	0	6	0	0	0	0
Dental Nurse	**5**	0	0	0	0	0	0	5	0	0	0	0
Dermatologist	**1**	0	0	0	0	0	0	1	0	0	0	0
EDCU Assistant	**246**	0	0	0	0	0	0	246	0	0	0	0
EHO	**117**	1	0	0	0	0	0	113	0	1	0	0
ENT Surgeon	**3**	2	0	0	0	0	0	1	0	0	0	0
Entomological Assistant	**8**	0	0	0	0	0	0	2	0	0	0	0
Epidemiological Assistant	**2**	0	0	0	0	0	0	8	0	0	0	0
Gyn/Obstetrician	**10**	3	0	0	0	0	0	7	0	0	0	0
Haematologist	**1**	0	0	0	0	0	0	1	0	0	0	0
House Officer	**6**	0	0	0	0	0	0	6	0	0	0	0
Health Educ. Officer	**4**	0	0	0	0	0	0	4	0	0	0	0
Lab. Assistant	**22**	0	0	2	0	3	0	17	0	0	0	0
Lab. Technician	**66**	0	0	4	0	7	0	44	0	0	0	0
Limb Fitter	**1**	0	0	0	0	0	0	1	0	0	0	0
MCH Aide	**1057**	10	0	9	0	11	0	1023	3	1	0	0
Medical Officer	**105**	24	1	4	2	8	2	55	1	7	0	1
Med. Officer (PH)	**7**	0	0	0	0	0	0	7	0	0	0	0
N/Anaesthetist	**17**	3	0	1	0	0	0	11	0	2	0	0
Nutritionist	**6**	0	0	2	0	0	0	4	0	0	0	0
Ophthalmic Nurse	**15**	0	0	0	0	0	0	14	0	1	0	0
Ophthalmic Tech.	**8**	0	0	6	0	0	0	2	0	0	0	0
Ophthalmologist	**1**	0	0	0	0	0	0	1	0	0	0	0
Orthopaedic Tech.	**5**	0	0	0	0	0	0	5	0	0	0	0
Orthopaedist	**1**	1	0	0	0	0	0	0	0	0	0	0
Paediatrician	**8**	4	0	0	0	1	0	3	0	0	0	0

Pathologist	**2**	0	0	0	0	0	0	2	0	0	0	0
Pharmacy Tech.	**256**	147	0	0	0	3	0	93	6	3	1	0
Pharmacist	**84**	72	0	0	0	0	0	11	0	1	0	0
Physician	**5**	3	0	0	0	1	0	1	0	0	0	0
Physiotherapist	**1**	0	0	0	0	0	0	1	0	0	0	0
Psychiatric Nurse	**1**	0	0	0	0	0	0	1	0	0	0	0
Psychiatrist	**1**	0	0	0	0	0	0	1	0	0	0	0
Pub. Heath Nurse	**48**	0	0	0	0	0	0	47	0	1	0	0
P/ Health Specialist	**20**	1	0	0	0	0	0	19	0	0	0	0
Radiographer	**4**	0	0	1	0	0	0	2	0	0	0	0
Radiologist	**2**	1	0	0	0	0	0	1	0	0	0	0
Refractionist	**2**	0	0	0	0	0	0	2	0	1	0	0
Sanitary Engineer	**1**	0	0	0	0	0	0	1	0	0	0	0
SCM	**242**	15	2	0	0	2	0	196	7	20	0	0
SECHN	**969**	101	18	33	0	78	3	626	20	76	13	1
SRN	**173**	34	6	5	0	4	6	109	2	2	1	4
Surgeon	**12**	0	0	2	0	0	0	9	0	1	0	0
X-Ray Tech	**2**	0	0	0	0	0	0	2	0	0	0	0
TOTAL	**3,736**											

Source: MOHS HRD Survey July 2004

3.4 MOHS Staff strength analysis

3.4.1 PHU staffing standards

The primary health care handbook gives the following staffing standards for PHUs.

TABLE 7 - PHU RECOMMENDED STAFFING STANDARDS

PHU	CHO	EHO	SECHN/CHA	MCHA	EDCU/VAC.
Community Health Centre (CHC	1	1	1	1	1
Community Health Post (CHP)	-	-	1	1	1
Maternal Child Health Post (MCHP)	-	-	-	1	1

Source: Primary Health Care Handbook, July 2004

Table 8 below shows large vacancies for EHOs at Community Health Centres and an over establishment of MCH Aides by 73%. There are large vacancies for SECHNs at CHP amounting to 89%.

TABLE 8 - VACANCY ANALYSIS FOR CURRENT MOHS OPERATIONAL PHUs

CADRE	No. OF CHC	TOTAL RECOMMENDED POSTS	No. IN POST	VACANCY	VACANCY RATE
	193				
CHO	"	193	98	-95	-49%
EHO	"	193	2	-191	-99%
SECHN	"	193	73	-120	-62%
MCH AIDE	"	193	333	+140	+73%
	No. of CHP				
SECHN	256	256	28	-228	-89%
MCH AIDE	"	256	172	-84	-33%
	No. of MCHP				
	338				
MCH AIDE	"	381	447	+66	-17%

Source of in-post figures MOHS HRD Survey, July 2004

NOTE: - denotes under establishment
+ denotes over establishment

3.4.2 Vacancy analysis for Hospitals

Table 9 below is an analysis by percentage of staff strength which reflects the number of personnel in post relative to MOHS tentative recommended staffing standards. For more details on these vacancy rates see annex 1. Large vacancies still exist for almost all cadres in all hospitals in MOHS. Specialized hospitals have large vacancies for specialized staff which invariably reduce their capability to fulfil their stated objectives.

It is important to note that to fill these large vacancies across the board would require massive investments both capital (additional training facilities, accommodation etc) and recurrent costs.

Table 9 - VACANCY ANALYSIS FOR CURRENT MOHS HOSPITALS BY PERCENTAGE

CADRE	Provincial Hospital	District Hospital	Children Hospital	Lakka Hospital	Connaught Hospital	PCM Hospital
Medical Officer	-81%	-65%	+17%	-50%	-48%	-44%
Physician	-83%	-	-	-	-100%	-
Surgeon	-89%	-	-	-	-44%	-
ENT Surgeon	-100%	-	-	-	0	-
Paediatrician	-100%	-	-50%	-	-	-
Obs/Gyn	-33%	-	-	-	-	-67%
Pathologist	-100%	-	-	-	-67%	-
Laboratory	-40%	-100%	-100%	-100%	-33%	-100%
Radiographer	-100%	-	-100%	-100%	-71%	-100%
Pharmacy Technician	+50%	-68%	-100%	-100%	+20%	-33%
Staff Midwives	+33%	-85%		-	-	-
SRN	-85%	-71%	-	-100%	-72%	-46.7%
SECHN	-41%	+1%	-	+50%	+20%	-93%
Ophthalmologist	-100%	-	-	-	-	-
Ophthalmic Technician	-100%	-100%	-	-	-	-
Ophthalmic Nurse	-100%	-97%	-	-	-	-
Dental Surgeon	-33%	-100%	-	-	-	-
Dental Technician	-100%	-100%	-	-	-	-
Nurse Anaesthetist	-80%	-89%	-	-	-50%	-75%
CHO	0	-73%	-	-	-	-

NOTE: - denotes under establishment
+ denotes over establishment

3.5 DISTRIBUTION OF MOHS WORKFORCE

3.5.1 Distribution of the workforce by grade and functional area

Table 10 below shows most Clinical services personnel in MOHS are in salary grade 9 and above. Grade 9 and above in clinical services represent medical officers and specialist. The nursing services personnel have none above salary grade 7. PHC has a good number of personnel in grade 9 and above. Most of these PHC personnel in these grades are public health specialist doctors. Pharmacy has three people in grade 9 and above.

There are many MOHS personnel not on payroll. Table 10 shows nursing services have more personnel not on payroll followed by the PHC group.

Nursing services salary grades need urgent attention as salary grades are one but very essential element in staff retention.

Table 10 - DISTRIBUTION OF MOHS PERSONNEL (CORE STAFF) BY SALARY GRADE AND BY FUNCTIONAL AREA

SALARY GRADE	NURSING	CLINICAL	PHARMACY	PHC	TOTAL
Not on pay roll	265	29	11	319	**624**
1	41	19	0	673	**734**
2	208	10	0	243	**462**
3	0	28	0	2	**30**
4	358	14	91	10	**473**
5	138	27	1	193	**364**
6	162	2	0	22	**186**
7	47	3	7	3	**60**
8	0	1	1	0	**4**
9	0	64	0	10	**74**
10	0	6	1	2	**9**
11	0	1	1	0	**2**
12	0	9	1	8	**18**
13	0	11	0	8	**19**
14	0	4	0	1	**5**

Source: Personnel Office, MOHS, July 2004

3.5.2 Distribution of MOHS Specialist Personnel

Table 11 below shows the number of Specialist personnel in MOHS and their distribution. Most specialists are in tertiary hospitals which include provincial hospitals. One specialist dermatologist is at Tonkolili district hospital. Some public health specialists are in management positions at MOHS headquarters as well as health related programmes. They are part of the 19 public health specialist.

Table 11 - DISTRIBUTION OF MOHS PRACTICING SPECIALIST PERSONNEL BY CADRE AND BY LEVEL OF CARE

SPECIALIZATION	TOTAL.	PROV HOS	%	DIST HOSP	%	CMS	%	CHDNS HOSP	%	KISSYMENTAL	%	LAKKA HOSP	%	PCM HOS	%	CON HOS	%	Other Govt. H/S *	%
Cardiologist	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	100	0	0
Dentist	5	2		0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	
Dermatologist	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gyn/Obstetrician	6	1	25.5	0	0	0	0	0	0	0	0	0	0	5	74.5	0	0	0	12.5
Haematologist	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	100	0	0
Paediatrician	3	0	0	0	0	0	0	3	100	0	0	0	0	0	0	0	0	0	0
Pathologist	2	0	0	1	50	0	0	0	0	0	0	0	0	0	0	1	50	0	0
Physician	1	1	100	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Psychiatrist	1	0	0	0	0	0	0	0	0	1		0	0	0	0	0	0	0	0
Public Health Specialist	19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	19	100
Radiologist	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	100	0	0
Surgeon	3	1	20	0	20	0	0	0	0	0	0	0	0	0	0	2	30	0	0
ENT Surgeon	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	100	0	0
% OF THE TOTAL	46	5	12.5	2	6.3	0	0	3	6.3	1	2.1	0	0	5	10.4	7	16.7	22	45.8

Source: MOHS HRD Survey, July 2004

H/S Means Health Services which include MOHS Headquarters

3.5.3 Distribution of Specialist Personnel by Geographical Region

Table 12 shows the distribution of MOHS specialist personnel by geographical administrative region. Most specialists are in Western Area in tertiary hospitals and at headquarters in administrative jobs. This can be explained by the fact that more specialist health care is available in the Western Area. There are more public health specialist in the Western Area than in other regions. This situation may impact negatively on the roles of provincial hospitals as regards their tertiary referral function. This may also impede some provincial hospitals ability to act effectively as teaching hospitals.

Table 12 - DISTRIBUTION OF MOHS SPECIALIST BY AREA OF SPECIALIZATION AND BY REGION

SPECIALISATION	TOTAL	WESTERN AREA	%	NORTHERN REGION	%	SOUTHERN REGION	%	EASTERN REGION	%
Cardiologist	**1**	1	100	0	0	0	0	0	0
Dentist	**5**	3	60	0	0	1	20	1	20
Dermatologist	**1**	0	0	1	100	0	0	0	0
Gyn/Obstetrician	**6**	5	75	0	0	1	25	0	0
Haematologist	**1**	1	100	0	0	0	0	0	0
Paediatrician	**3**	3	100	0	0	0	0	0	0
Pathologist	**2**	2	100	0	0	0	0	0	0
Physician	**1**	0	0	0	0	0	0	0	100
Psychiatrist	**1**	1	100	0	0	0	0	0	0
Public Health Specialist	**19**	12	68.5	2	10.5	2	10.5	2	10.5
Radiologist	**1**	1	100	0	0	0	0	0	0
Surgeon	**3**	2	60	0	0	1	20	0	20
ENT Surgeon	**1**	1	100	0	0	0	0	0	0
% OF THE TOTAL	**46**	34	66.7	3	6.3	5	10.4	3	14.6

Source: MOHS HRD Survey 2004

3.5.4 Distribution of MOHS Personnel by Level of Care

Table 13 below shows disparity in the numbers of staff by level of care. Most EHO and SECHNs are in provincial and district facilities. The two cadres' place of work is at Primary Health Care level. Primary Health Care level has a large number of MCH Aides which may be doing the work of the inadequate SECHNs. The general staff shortage at many facilities is more acute at Primary Health units. This is probably one of the major reasons why patients may not seek first level of care from Primary Health units. A number of reasons for this chronic problem have been suggested. They include lack of basic services and facilities which include decent accommodation, circuitous and lengthy recruitment process that does not attract potential recruits, professional isolation, lack of recognition, overwork and burn-out from constantly working without basic supplies. While it is not enough to find solutions to all these problems, a concerted effort will need to be made to address them.

The picture being portrayed here is that deployment of personnel is not in line with the Ministry's health care delivery strategy and calls for a deployment policy within HRM policy that conforms to health care delivery strategies and policy.

Table 13 - DISTRIBUTION OF MOHS PERSONNEL (CORE STAFF) BY CADRE AND BY LEVEL OF CARE

CADRE	TOTAL	PRO HOS	DIST HOS	CHC	CHP	MCHP	CMS	CHDN HOSP	KISSY MENTAL	LAKKA HOSP	PCM HOSP	CONN HOSP	Other Govt H/S
Anaesthetist	1	0	0	0	0	0	0	0	0	0	0	1	0
Biochemist	5	1	1	0	0	0	0	0	0	0	0	3	0
Cardiologist	1	0	0	0	0	0	0	0	0	0	0	1	0
CHO	132	8	8	98	4	1	0	0	0	0	0	0	13
Chiropodist	1	0	0	0	0	0	0	0	0	0	0	1	0
Dental Surgeon	5	2	0	0	0	0	0	0	0	0	0	0	3
Dental Nurse	2	0	0	0	0	0	0	0	0	0	0	0	2
Dental Technician	6	0	0	0	0	0	0	0	0	0	0	0	6
Dermatologist	1	0	1	0	0	0	0	0	0	0	0	0	0
EDCU Assistant	247	3	13	58	88	13	0	3	0	0	0	1	68
Entomological Asst.	2		0	0	0	0	0	0	0	0	0	0	2
EHO	113	0	5	2	0	0	0	0	0	0	0	1	105
Epidemiological Asst	2	0	0	0	0	0	0	0	0	0	0	0	2
Gyn/Obstetrician	7	2	0	0	0	0	0	0	0	0	5	0	1
Haematologist	1	0	0	0	0	0	0	0	0	0	0	1	0
House Officer	6	0	0	0	0	0	0	0	0	0	0	6	0
Health Educ. Officer	4	0	0	0	0	0	0	0	0	0	0	0	4

Lab. Assistant	17	3	5	1	0	0	0	1	0	2	0	3	2
Lab. Technician	48	9	18	1	0	0	0	1	0	4	0	14	1
Limb Fitter	1	0	0	0	0	0	0	0	0	0	0	0	1
MCH Aide	1023	3	51	333	172	447	0	0	0	0	0	0	17
Medical Officer	59	10	21	0	0	0		7	0	1	5	13	2
Med. Officer (PH)	7	0	0	0	0	0	0	0	0	0	0	0	7
N/Anaesthetist	11	3	5	0	0	0	0	0	0	0	1	2	0
Nutritionist	4	0	0	0	0	0	0	1	0	0	0	1	2
Ophthalmologist	1	0	0	0	0	0	0	0	0	0	0	1	0
Ophthalmic Nurse	14	0	1	0	0	0	0	0	0	0	0	13	0
Ophthalmic Tech.	2	0	0	0	0	0	0	0	0	0	0	2	0
Orthopaedic Tech.	5	0	0	0	0	0	0	0	0	0	0	0	5
Paediatrician	3	0	0	0	0	0	0	3	0	0	0	0	0
Pathologist	2	0	0	0	0	0	0	0	0	0	0	1	1
Pharmacist	13	0	0	0	0	0	9	1	0	0	1	0	2
Pharmacy Tech.	91	18	24	14	8	0	0	0	2	0	4	12	19
Physician	1	1	0	0	0	0	0	0	0	0	0	0	0
Physiotherapist	1	0	0	0	0	0	0	0	0	0	0	1	0
Psychiatric Nurse	1	0	0	0	0	0	0	0	1	0	0	0	0
Psychiatrist	1	0	0	0	0	0	0	0	1	0	0	0	0
Pub. Health Nurse	47	0	0	0	0	0	0	2	0	0	2	4	39
P/ Health Specialist	19	0	0	0	0	0	0	0	0	0	0	0	19
Radiographer	2	0	0	0	0	0	0	0	0	0	0	2	0
Radiologist	1	0	0	0	0	0	0	0	0	0	0	1	0
Refractionist	2	0	0	0	0	0	0	0	0	0	0	2	0
Sanitary Engineer	1	0	0	0	0	0	0	0	0	0	0	0	1
SCM	197	28	58	6	0	0	0	10	0	2	51	25	17
SECHN	653	91	211	73	28	5	0	38	1	9	58	79	60
SRN	112	20	44	0	0	0	0	21	1	0	0	24	2
Surgeon	5	1	1	0	0	0	0	0	0	0	0	3	0
ENT Surgeon	1	0	0	0	0	0	0	0	0	0	0	1	0
X-Ray Tech	2	2	0	0	0	0	0	0	0	0	0	0	0

Source: MOHS HRD Survey, July 2004

3.5.5 Distribution of MOHS Personnel by Health Programme

Table 14 below shows small number of staff in various health programmes. This situation is a major bottleneck in effective delivery of health programmes activities nationally. The programme with least technical staff is the HIV/AIDS programme.

Table 14 - DISTRIBUTION OF MOHS PERSONNEL (CORE CADRE) BY CADRE AND BY HEALTH PROGRAMME

CADRE	TOT	MAL	HIV/ AIDS	ONCHO	MCH/ EPI	RH/FP	IMCI	FOOD & NUTR	SCH HEALTH	ENV HEALTH	H/ED	DPC.
CHO	2	1	0	0	0	0	0	0	1	0	0	0
EDCU Assistant	3	0	0	0	3	0	0	0	0	0	0	0
EHO	46	0	0	1	0	0	0	0	0	36	5	4
Epidemiological Asst.	2	0	0	0	2	0	0	0	0	0	0	0
Health Educ. Officer	4	0	0	0	0	0	0	0	0	0	4	0
MCH Aide	1	0	0	1	0	0	0	0	0	0	0	0
Medical Officer	1	0	0	0	0	1	0	0	0	0	0	0
Med. Officer (PH)	1	1	0	0	0	0	0	0	0	0	0	0
Nutritionist	4	0	0	0	0	0	0	4	0	0	0	0
Paediatrician	1	0	0	0	0	0	1	0	0	0	0	0
Pharmacy Tech.	2	0	0	0	0	0	0	0	2	0	0	0
Pub. Heath Nurse	11	4	0	1	3	3	0	0	0	0	0	0
P/ Health Specialist	7	0	1	1	1	1	0	0	1	0	0	2
SCM	3	0	0	0	0	0	0	0	3	0	0	0
SECHN	10	0	0	0	1	1	0	0	5	1	1	1
SRN	3	0	0	0	3	0	0	0	0	0	0	0

Source: MOHS HRD Survey, July 2004

3.5.6 Distribution of MOHS staff by Rural/Urban split (rural include MCHP and CHP)

Table 15 below shows the rural/urban distribution of MOHS personnel by cadre indicating a great concentration of personnel in urban areas.

Currently there are substantial differences in the access to qualified health personnel for rural and urban populations. Within districts resources are heavily concentrated in the areas in which district hospitals are located.

Obviously, since a district hospital is a referral centre and its surrounding area is relatively densely populated, some concentration is to be expected: But there are also marked inequalities in population-to-personnel ratios at the sub-district level.

Part of the problem is that rational staffing patterns have not been used. Fortuitous factors have often played their part in bringing about this irrational situation. Under staffing of rural facilities has led to lack of confidence in smaller facilities as they are perceived as incapable of meeting people's needs. Such factors have possibly impinged on the efficiency of staff utilization.

It is reported that most staff redeployed to rural facilities do not report at their new stations. In Pujehun and Kailahun MOHS personnel posted to district hospitals have ended up in the hands of MSF-France an NGO offering health services in these districts depriving government of the much needed staff.

Table 15 - DISTRIBUTION OF MOHS PERSONNEL (CORE STAFF) BY CADRE AND BY URBAN/RURAL

CADRE	TOTAL	URBAN	%	RURAL	%
Anaesthetist	1	1	100	0	0
Biochemist	5	5	100	0	0
Cardiologist	1	1	100	0	0
CHO	132	111	84.0	21	16.0
Chiropodist	1	1	100	0	0
Dentist	5	5	100	0	0
Dental Nurse	2	2	100	0	0
Dental Tech.	6	6	100	0	0

Dermatologist	1	1	100	0	0
EDCU Assistant	247	126	51.0	121	49.0
Entomological Assistant	2	2	100	0	0
EHO	113	93	82.3	20	17.7
Epidemiological Assistant	2	2	100	0	0
Gyn/Obstetrician	7	7	100	0	0
Haematologist	1	1	100	0	0
House Officer	6	6	100	0	0
Health Education Officer	4	4	100	0	0
Lab. Assistant	17	17	100	0	0
Lab. Technician	48	46	95.8	2	4.2
Limb Fitter	1	1	100	0	0
MCH Aide	1023	328	32.0	695	68.0
Medical Officer	59	59	100	0	0
Med. Officer (PH)	7	7	100	0	0
N/Anaesthetist	11	11	100	0	0
Nutritionist	4	4	100	0	0
Ophthalmologist	1	1	100	0	0
Ophthalmic Nurse	14	14	100	0	0
Ophthalmic Tech.	2	2	100	0	0
Orthopaedic Tech.	5	5	100	0	0
Paediatrician	3	3	100	0	0
Pathologist	2	2	100	0	0
Pharmacist	13	13	100	0	0
Pharmacy Tech.	91	82	90.1	9	8.9
Physician	1	1	100	0	0
Physiotherapist	1	1	100	0	0
Psychiatric Nurse	1	1	100	0	0
Psychiatrist	1	1	100	0	0
Pub. Health Sister	47	47	100	0	0
Public Health Specialist	19	19	100	0	0
Radiographer	2	2	100	0	0
Radiologist	1	1	100	0	0
Refractionist	2	2	100	0	0
Sanitary Engineer	1	1	100	0	0
SCM	197	186	94.4	11	5.6
SECHN	653	560	85.7	93	14.3
SRN	112	107	95.5	5	4.5
Surgeon	5	5	100	0	0
Surgeon (ENT)	1	1	100	0	0
X-Ray Technician	2	2	100	0	0

Source: MOHS HRD Survey, July 2004

3.5.7 Distribution of MOHS Personnel by Age

Age of persons employed within the health service is of importance because age distribution determines the time of staff losses due to retirement and has a number of other implications relating to career progression and staff mobility. Table 16 below gives age distribution of MOHS staff where known.

It can be seen that most professional staff are less than 44 years old. Most SECHNs are less than 44 years.

In some cases there are some personnel who have passed the mandatory retirement age of 60 such as some Medical Officers, State Certified Midwives, and MCH Aides.

Age distribution analysis also indicates to the authorities the need for succession planning for officers in age bracket 55-59, who are about to retire. Officers in age bracket 55-59 should not be attaining long-term training as the MOHS is likely to lose.

Table 16 also reveals that over a quarter of the current MOHS workforce will be lost through retirement during the plan period. Effectively the training outputs entering MOHS may only fill vacancies created by retirement wastage hence maintain the status quo in staffing.

Table 16 - DISTRIBUTION OF MOHS PERSONNEL (CORE STAFF) BY CADRE AND BY AGE GROUP

FUNCTION/ CADRE	AGE GROUP											
	Age Not Stated	< 20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	TOTAL
Anaesthetist	1	0	0	0	0	0	0	0	0	0	0	1
Biochemist	1	0	0	0	0	0	0	1	2	0	1	5
Cardiologist	0	0	0	0	0	0	0	0	0	1	0	1
Chiropodist	0	0	0	0	0	0	0	0	0	1	0	1
CHO	12	0	0	2	15	43	41	14	4	1	0	132
Dental Surgeon	0	0	0	0	0	0	2	1	0	2	0	5
Dental Technician	0	0	0	0	0	0	0	2	1	3	0	6
Dental Nurse	0	0	0	0	0	0	0	1	1	0	0	2
Dermatologist	0	0	0	0	0	0	0	0	0	1	0	1
EDCU Assistant	23	0	0	1	5	28	64	45	61	18	2	247
Entomological Assistant	0	0	0	0	0	0	0	1	1	0	0	2
EHO	8	0	0	0	23	19	15	25	15	8	0	113
Epidemiological Assistant	0	0	0	0	0	0	0	1	1	0	0	2
Gyn/Obstetrician	1	0	0	0	0	0	0	0	2	3	1	7
Haematologist	0	0	0	0	0	0	0	1	0	0	0	1
House Officer	0	0	0	0	4	2	0	0	0	0	0	6
Health Educ. Officer	0	0	0	0	0	0	1	2	1	0	0	4
Lab. Assistant	0	0	2	0	1	5	4	1	1	2	1	17
Lab. Technician	4	0	1	1	4	6	6	11	8	6	1	48
Limb Fitter	0	0	0	0	0	0	0	0	0	0	1	1
MCH Aide	224	0	4	66	172	198	133	114	73	32	7	1023
Medical Officer	8	0	0	3	10	10	9	7	3	5	4	59
Med. Officer (PH)	0	0	0	0	0	0	2	5	0	0	0	7
N/Anaesthetist	3	0	0	0	1	1	3	0	0	3	0	11
Nutritionist	0	0	0	0	0	2	1	0	1	0	0	4
Ophthalmologist	1	0	0	0	0	0	0	0	0	0	0	1
Ophthalmic Nurse	2	0	0	2	2	1	3	4	0	0	0	14
Ophthalmic Tech.	0	0	0	0	0	1	0	1	0	0	0	2
Orthopaedic Tech.	0	0	0	0	0	1	0	1	3	0	0	5
Paediatrician	0	0	0	0	0	0	1	1	0	1	0	3
Pathologist	0	0	0	0	0	0	0	0	0	2	0	2
Pharmacist	0	0	0	0	2	2	1	0	4	4	0	13
Pharmacy Tech.	3	0	0	0	0	3	11	19	31	19	5	91
Physician	0	0	0	0	0	0	0	0	0	0	1	1
Physiotherapist	0	0	0	0	0	0	0	1	0	0	0	1
Psychiatric Nurse	0	0	0	0	0	1	0	0	0	0	0	1

Psychiatrist	0	0	0	0	0	0	0	0	0	0	1	1
Pub. Heath Sister	1	0	0	0	3	19	13	8	2	1	0	47
P/ Health Specialist	0	0	0	0	0	1	2	8	4	4	0	19
Radiographer	0	0	0	0	0	0	0	1	0	1	0	2
Radiologist	0	0	0	0	0	1	0	0	0	0	0	1
Refractionist	0	0	0	0	0	1	1	0	0	0	0	2
Sanitary Engineer	0	0	0	0	0	0	0	1	0	0	0	1
SCM	8	0	0	2	23	29	32	32	51	16	4	197
SECHN	75	0	8	67	110	139	147	71	20	16	0	653
SRN	13	0	2	22	37	22	9	5	2	0	0	112
Surgeon	0	0	0	0	0	0	1	1	1	1	1	5
ENT Surgeon	1	0	0	0	0	0	0	0	0	0	0	1
X-Ray Tech	0	0	0	0	0	1	1	0	0	0	0	2
X-Ray Assistant	0	0	0	0	0	1	1	1	0	0	0	3
Tot. No. in age group	389	0	17	166	412	537	504	387	293	151	31	2886

Source: MOHS HRD Survey, July 2004

3.5.8 Distribution of MOHS Personnel by Sex

Table 18 below shows distribution of MOHS technical staff by cadre, level of care and sex. There are more males than females. Females dominate the Nursing Cadre. As already stated females in nursing services are poorly graded.

Table 17 - DISTRIBUTION OF MOHS PERSONNEL (CORE STAFF) BY CADRE BY LEVEL OF CARE AND BY SEX

FUNCTION/CADRE	TOTAL		PROV HOSP		DIST HOSP		PHUs		CMS		CHDN'S HOSP		KISSY MENTAL		PCM		LAKKA HOSP		CONN HOSP		Other Govt H/S	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Anaesthetist	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Biochemist	4	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	0
Cardiologist	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
CHO	120	12	7	1	8	0	92	11	0	0	0	0	0	0	0	0	0	0	0	0	13	1
Chiropodist	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Dental Surgeon	5	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0
Dental Technician	2	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	4
Dental Nurse	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Dermatologist	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
EDCU Assistant	245	2	3	0	13	0	158	1	0	0	3	0	0	0	0	0	0	0	0	1	68	0
Entomological Assistant	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
EHO	104	9	0	0	4	1	2	0	0	0	0	0	0	0	0	0	0	0	1	0	97	8
Epidemiological Asst.	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Gyn/Obstetrician	7	0	2	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0
Haematologist	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
House Officer	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Health Educ. Officer	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	1
Lab. Assistant	14	3	3	0	3	2	1	0	0	0	1	0	0	0	0	0	2	0	2	1	2	0
Lab. Technician	44	4	9	0	17	1	1	0	0	0	1	0	0	0	0	0	3	1	12	2	1	0
Limb Fitter	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
MCH Aide	0	1023	0	3	0	51	0	952	0	0	0	0	0	0	0	0	0	0	0	0	0	17
Medical Officer	47	12	10	0	20	1	0	0	0	0	5	2	0	0	1	4	1	0	8	5	2	0
Med. Officer (PH)	6	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	1
N/Anaesthetist	9	4	1	2	5	0	0	0	0	0	0	0	0	0	1	0	0	0	2	0	0	0
Nutritionist	0	4	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	2
Ophthalmologist	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Ophthalmic Nurse	6	8	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	6	7	0	0
Ophthalmic Tech	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
Orthopaedic Tech	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0
Paediatrician	3	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0
Pathologist	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
Pharmacist	12	1	0	0	0	0	0	0	8	1	1	0	1	0	0	0	0	0	0	0	2	0
Pharmacy Tech.	89	2	18	0	24	0	22	0	0	0	0	0	2	0	4	0	0	0	12	0	7	2
Physician	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physiotherapist	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0

Psychiatric Nurse	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Psychiatrist	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Pub. Heath Nurse	3	44	0	0	0	0	0	0	0	0	0	2	0	0	0	2	0	0	0	3	3	36
P/ Health Specialist	19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	19	0
Radiographer	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0
Radiologist	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Refractionist	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0
Sanitary Engineer	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
SCM	0	197	0	28	0	58	0	6	0	0	0	10	0	0	0	51	0	2	0	25	0	17
SECHN	157	496	26	65	50	161	51	55	0	0	1	37	0	1	0	58	6	3	9	70	14	46
SRN	19	93	1	19	7	37	0	0	0	0	4	17	0	0	0	1	0	0	6	18	1	1
Surgeon	5	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	1	0
ENT Surgeon	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
X-Ray Technician	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Source: MOHS HRD survey, July 2004

3.5.9 Distribution of Health Personnel by Location

Table 19 shows access to MOHS qualified personnel through population/personnel ratios by cadre, function and district. Table 19 reveals that Western Area population is well served by Clinical, Pharmacy and Nursing services. Primary care serves are relatively limited to the population of Western Area as shown by lower personnel population ratios of Primary care personnel.

Table 18 - POPULATION PER HEALTH PERSONNEL BY CADRE AND BY DISTRICT

DISTRICT >	SIERRA LEONE		BO		BONTHE		BOMBALI		KAMBIA		KOINADUGU		PORT LOKO	
POPULATION >	6,371,698		388,815		143,328		490,389		337,212		304,988		536,058	
CADRE	No	Pop/Cadre	No	Pop/Cadre	No	Pop/Cadre	No	Pop/Cadre	No.	Pop/Cadre	No.	Pop/Cadre	No.	Pop/Cadre
CLINICAL.	308	20,687	23	16,905	5	28,666	5	98,078	1	337,212	2	152,494	21	25,527
Anaesthetist	1	6,371,698	0	0	0	0	0	0	0	0	0	0	0	0
Biochemist	5	1,274,340	0	0	0	0	0	0	0	0	0	0	0	0
Cardiologist	1	6,371,698	0	0	0	0	0	0	0	0	0	0	0	0
Dental Technician	6	1,061,950	0	0	0	0	0	0	0	0	0	0	0	0
Dentist	5	1,274,340	1	388,815	0	0	0	0	0	0	0	0	0	0
Dermatologist	1	6,371,698	0	0	0	0	0	0	0	0	0	0	0	0
Gyn/Obstetrician	11	579,245	1	388,815	0	0	0	0	0	0	0	0	0	0
Haematologist	1	6,371,698	0	0	0	0	0	0	0	0	0	0	0	0
House Officer	6	1,061,950	0	0	0	0	0	0	0	0	0	0	0	0
Lab Assistant	22	289,623	1	388,815	1	143,328	2	245,195	0	0	1	304,988	4	134,015
Lab Technician	64	99,558	6	64,803	0	0	1	490,389	0	0	0	0	5	107,212
Limb Fitter	1	6,371,698	0	0	0	0	0	0	0	0	0	0	0	0
Medical Officer	111	57,403	9	43,202	4	35,832	2	245,195	1	337,212	1	304,988	2	268,029
Nurse Anaesthetist	17	374,806	1	388,815	0	0	0	0	0	0	0	0	1	536,058
Ophthalmic Tech.	8	796,462	0	0	0	0	0	0	0	0	0	0	6	89,343
Ophthalmologist	1	6,371,698	0	0	0	0	0	0	0	0	0	0	0	0
Orthopaedic Surgeon	1	6,371,698	0	0	0	0	0	0	0	0	0	0	0	0
Orthopaedic Tech.	5	1,274,340	0	0	0	0	0	0	0	0	0	0	0	0
Paediatrician	8	796,462	0	0	0	0	0	0	0	0	0	0	0	0
Pathologist	2	3,185,849	0	0	0	0	0	0	0	0	0	0	0	0
Physician	5	1,274,340	1	388,815	0	0	0	0	0	0	0	0	1	536,058
Physiotherapist	1	6,371,698	0	0	0	0	0	0	0	0	0	0	0	0
Psychiatrist	1	6,371,698	0	0	0	0	0	0	0	0	0	0	0	0
Radiographer	4	1,592,925	0	0	0	0	0	0	0	0	0	0	1	536,058
Radiologist	2	3,185,849	0	0	0	0	0	0	0	0	0	0	0	0

Refractionist	2	3,185,849	0	0	0	0	0	0	0	0	0	0	0	0
Surgeon	12	530,975	1	388,815	0	0	0	0	0	0	0	0	1	536,058
Surgeon ENT	2	3,185,849	0	0	0	0	0	0	0	0	0	0	0	0
X-Ray Tech.	2	3,185,849	2	194,408	0	0	0	0	0	0	0	0	0	0
NURSING.	**1434**	**4,443**	**135**	**2880**	**28**	**5,119**	**21**	**23,352**	**15**	**22,481**	**12**	**25,416**	**47**	**11,405**
Chiropodist	1	6,371,698	0	0	0	0	0	0	0	0	0	0	0	0
Dental Nurse	2	3,185,849	0	0	0	0	0	0	0	0	0	0	0	0
Ophthalmic Nurse	15	424,780	0	0	0	0	0	0	0	0	1	304,988	0	0
Psychiatric Nurse	1	6,371,698	0	0	0	0	0	0	0	0	0	0	0	0
SCM	243	26,221	16	24,310	1	143,328	4	122,597	3	112,404	2	152,494	4	134,015
SECHN	996	6,397	100	3,888	26	5,513	12	40,866	12	28,101	7	43,570	35	15,316
SRN	176	36,203	19	20,464	1	143,328	5	98,078	0	0	2	152,494	8	67,007
PHARMACY.	**340**	**18,740**	**44**	**8,837**	**5**	**28,666**	**5**	**98,078**	**0**	**0**	**3**	**101,663**	**4**	**134,015**
Pharmacist	86	74,090	13	29,909	0	0	0		0	0	0	0	1	536,058
Pharmacy Tech/Disp	254	25,085	31	12,961	5	28,666	5	98,078	0	0	3	101,663	3	178,686
PHC.	**1,681**	**3,790**	**260**	**1,495**	**56**	**2,559**	**141**	**3,478**	**87**	**3,876**	**76**	4,013	133	4,031
CHO	170	37,481	44	8,837	3	47,776	6	81,732	5	67,442	2	152494	12	44,672
EDCU Assistant	247	25,796	57	6,821	7	20,475	25	19,616	8	42,152	10	30499	15	35,737
EHO	117	54,459	9	43,202	2	71,664	7	70,056	6	56,202	4	76247	8	67,007
Entomological Asst	2	3,185,849	0	0	0	0	0		0	0	0	0	0	0
Epidemiological Asst.	2	3,185,849	0	0	0	0	0	0	0	0	0	0	0	0
Health Educ. Officer	4	1,592,925	0	0	0	0	1	490,389	0	0	0	0	0	0
MCH Aide	1057	6,028	146	2,663	42	3,413	99	4,953	65	5,188	57	5,446	93	5,764
Medical Officer(PH)	7	910,243	1	388,815	0	0	0	0	1	337,212	1	304,988	1	536,058
Nutritionist	6	1,061,950	0	0	0	0	0	0	0	0	0	0	2	268,029
Public Health Nurse	48	132,744	2	194,408	2	71,664	2	245,195	2	168,606	2	152,494	2	268,029
Public Health Spec	20	318,585	1	388,815	0	0	1	490,389	0	0	0	0	0	0
Sanitary Engineer	1	6,371,698	0	0	0	0	0	0	0	0	0	0	0	0
PHC	**1681**	**3,790**	**260**	**1,495**	**56**	**2,559**	**141**	**3,478**	**87**	**3,876**	**76**	4,013	**133**	**4,031**

Source for Population Figures: Revised PHC Handbook, June 2004

Table 19 contd - POPULATION PER HEALTH PERSONNEL BY CADRE AND BY DISTRICT

DISTRICT >	SIERRA LEONE		KAILAHUN		KENEMA		KONO		MOYAMBA		PUJEHUN		TONKOLILI		W/AREA	
POPULATION >	6,371,698		373,405		519,875		508,611		459,926		242,648		734,423		1,332,020	
CADRE	No	Pop/ Cadre	No	Pop/ Cadre	No	Pop/ Cadre	No	Pop/ Cadre	No.	Pop/ Cadre	No.	Pop/ Cadre	No.	Pop/ Cadre	No.	Pop/ Cadre
CLINICAL.	**302**	**21,098**	**11**	**33,946**	**19**	**27,362**	**7**	**72,659**	**5**	**91,985**	**2**	**121,324**	**11**	**66,766**	**196**	**6,796**
Anaesthetist	**1**	**6,371,698**	0	0	0	0	0	0	0	0	0	0	0	0	1	1,332,020
Biochemist	**5**	**1,274,340**	0	0	1	519,875	1	508,611	0	0	0	0	0	0	3	444,007
Cardiologist	**1**	**6,371,698**	0	0	0	0	0	0	0	0	0	0	0	0	1	1,332,020
Dental Technician	**6**	**1,061,950**	0	0	0	0	0	0	0	0	0	0	0	0	6	222,003
Dentist	**5**	**1,274,340**	0	0	1	519,875	0	0	0	0	0	0	0	0	3	444,007
Dermatologist	**1**	**6,371,698**	0	0	0	0	0	0	0	0	0	0	1	734,423	0	0
Gyn/Obstetrician	**11**	**579,245**	0	0	2	259,938	0	0	0	0	0	0	0	0	8	166,503
Haematologist	**1**	**6,371,698**	0	0	0	0	0	0	0	0	0	0	0	0	1	1,332,020
House Officer	**6**	**1,061,950**	0	0	0	0	0	0	0	0	0	0	0	0	6	222,003
Lab Assistant	**22**	**289,623**	3	124,468	1	519,875	0	0	0	0	0	0	0	0	9	148,002
Lab Technician	**64**	**99,558**	3	124,468	5	103,975	1	508,611	3	153,309	1	242,648	4	183,606	35	38,058
Limb Fitter	**1**	**6,371,698**	0	0	0	0	0	0	0	0	0	0	0	0	1	1,332,020
Medical Officer	**111**	**57,403**	3	124,468	5	103,975	4	127,153	2	229,963	1	242,648	3	244,808	74	18,000
Nurse Anaesthetist	**17**	**374,806**	0	0	2	259,938	1	508,611	0	0	0	0	3	244,808	9	148,002
Ophthalmic Tech.	**8**	**796,462**	0	0	0	0	0	0	0	0	0	0	0	0	2	666,010
Ophthalmologist	**1**	**6,371,698**	0	0	0	0	0	0	0	0	0	0	0	0	1	1,332,020
Orthopaedic Surgeon	**1**	**6,371,698**	0	0	0	0	0	0	0	0	0	0	0	0	1	1,332,020
Orthopaedic Tech.	**5**	**1,274,340**	0	0	0	0	0	0	0	0	0	0	0	0	5	266,404
Paediatrician	**8**	**796,462**	1	373,405	0	0	0	0	0	0	0	0	0	0	7	190,289
Pathologist	**2**	**3,185,849**	0	0	0	0	0	0	0	0	0	0	0	0	2	666,010
Physician	**5**	**1,274,340**	1	373,405	1	519,875	0	0	0	0	0	0	0	0	1	1,332,020
Physiotherapist	**1**	**6,371,698**	0	0	0	0	0	0	0	0	0	0	0	0	1	1,332,020
Psychiatrist	**1**	**6,371,698**	0	0	0	0	0	0	0	0	0	0	0	0	1	1,332,020
Radiographer	**4**	**1,592,925**	0	0	0	0	0	0	0	0	0	0	0	0	3	444,007
Radiologist	**1**	**6,371,698**	0	0	0	0	0	0	0	0	0	0	0	0	2	666,010
Refractionist	**2**	**3,185,849**	0	0	0	0	0	0	0	0	0	0	0	0	2	666,010
Surgeon	**12**	**530,975**	0	0	1	519,875	0	0	0	0	0	0	0	0	9	148,002
Surgeon ENT	**2**	**3,185,849**	0	0	0	0	0	0	0	0	0	0	0	0	2	666,010
X-Ray Tech.	**2**	**3,185,849**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NURSING.	**1,375**	**4,634**	**62**	**6,023**	**78**	**6,665**	**27**	**18,837**	**30**	**15,331**	**13**	**18,665**	**23**	**31,931**	**943**	**1,413**
Chiropodist	**1**	**6,371,698**	0	0	0	0	0	0	0	0	0	0	0	0	1	1,332,020
Dental Nurse	**2**	**3,185,849**	0	0	0	0	0	0	0	0	0	0	0	0	2	666,010
Ophthalmic Nurse	**15**	**424,780**	0	0	0	0	0	0	0	0	0	0	0	0	14	95,114
Psychiatric Nurse	**1**	**6,371,698**	0	0	0	0	0	0	0	0	0	0	0	0	1	1,332,020
SCM	**230**	**27,703**	5	74,681	13	39,990	6	84,769	4	114,9892	1	242,648	4	183,606	180	7,400
SECHN	**960**	**6,637**	52	7,181	63	8,252	14	36,329	26	17,689	10	24,265	17	43,201	622	2,142

SRN	**166**	**38,384**	5	74,681	2	259,938	7	72,659	0	0	2	121,324	2	367,212	123	10,829
PHARMACY.	**337**	**18,907**	**3**	**124,468**	**7**	**74,268**	**12**	**42,384**	**11**	**41,811**	**4**	**60,662**	**2**	**367,212**	**240**	**5,550**
Pharmacist	**86**	**74,090**	0	0	0	0	1	508,611	1	459,926	0	0	0	0	70	19,029
Pharmacy Tech/Disp	**251**	**25,385**	3	124,468	7	74,268	11	46,237	10	45,993	4	60,662	2	367,212	170	7,835
PHC	**1,675**	**3,804**	**90**	**4,149**	**131**	**3,969**	**123**	**4,135**	**147**	**3,129**	**67**	**3,622**	**111**	**6,616**	**259**	**5,143**
CHO	**170**	**37,481**	16	23,338	18	28,882	12	42,384	11	41,811	5	48,530	5	146,885	31	42,968
EDCU Assistant	**247**	**25,796**	22	16,973	30	17,329	25	20,344	11	41,811	13	18,665	10	73,442	14	95,144
EHO	**117**	**54,459**	7	53,344	9	57,764	5	101,722	2	229,963	4	60,662	3	244808	51	26,118
Entomological Asst	**2**	**3,185,849**	0	0	0	0	0	0	0		0	0	0	0	2	666,010
Epidemiological Asst.	**2**	**3,185,849**	0	0	0	0	0	0	0		0	0	0	0	2	666,010
Health Educ. Officer	**4**	**1,592,925**	0	0	1	519,875	0	0	0		0	0	0	0	2	666,010
MCH Aide	**1051**	**6,063**	42	8,891	70	7,427	76	6,692	120	3833	42	5,777	90	8,160	115	11,583
Medical Officer(PH)	**7**	**910,243**	1	373,405	0	0	0	0	1	459,926	0	0	0	0	1	1,332,020
Nutritionist	**6**	**1,061,950**	0	0	0	0	0	0	0		0	0	0	0	4	333,005
Public Health Nurse	**48**	**132,744**	2	186,703	2	259,938	3	169,537	2	229,963	2	121,324	2	367,212	23	57,914
Public Health Spec	**20**	**318,585**	0	0	1	519,875	2	254,306	0		1	242,648	1	734,423	13	102,463
Sanitary Engineer	**1**	**6,371,698**	0	0	0	0	0	0	0		0		0	0	1	1,332,020

Source for Population Figures: Revised PHC Handbook, June 2004

3.6 Workforce flows

As already stated data on wastage was difficult to capture as health institutions do not keep staff records. However indications are that most people left the service during the war of the 90's. There are also a large number of MOHS personnel who have left for the non- governmental sector. The attrition rates used in this document are therefore assumed.

3.7 Recruitment

In order to recruit, there must be a vacancy and the post must be funded. People to be recruited must have minimum qualifications. Promotions depend on seniority (date of appointment) and qualifications and that there should be a vacancy at the grade above.

In order **to recruit and promote,** the DMOs have to inform the Director General of Medical Services who refers the matter to the Personnel officer at the MOHS headquarters. The Personnel Manager in turn seeks permission from the Establishment Secretary, who considers the feasibility of filling the post. The Public Service Commission (PSC) is subsequently informed to recruit an officer of a certain grade, after the Establishment Secretary has approved it. Recruitment of trained health personnel (new graduates) is sometimes delayed for over 5 years.

There are two aspects of **Deployment:**

- **Placement of those entering the Service:** the Establishment Secretary makes appointments and subsequently notifies the Director General of Medical Services (who is the Chairman of the MOHS Postings Committee) of these appointments. The Posting Committee sends these new entrants to the District Health Management Teams (DHMT). The allocation of these new entrants based on institutional needs, which the DHMT send to various directors a priori. It is the duty of the District Medical Officer to place them in the facilities within his/her jurisdiction i.e. Community Health Centre (CHC), Community Health Post (CHP), and Maternal and Child Health Post (MCHP).

- **Transfers/Postings:** this is for serving officers. A posting is done on the basis of a need existing at some institution, and in the interest of service. Each Head of department proposes transfers, which are taken to the Ministry's Transfers/Postings Committee. Upon the approval of this Committee, its Chairman issues relevant letters of postings to the concerned individuals. The Posting Committee is responsible for national/inter-district/inter-regional transfers only. Intra-district transfers/postings are the responsibility of the DMO. It is reported that, in practice, transfers can result from political pressure or specific organisational action against an individual. In some cases especially with nurses, transfers are made to allow them to follow their husbands who work predominantly in urban areas.

The MOHS experiences some problems in filling posts:

- The reporting of vacancies for filling is long as they are many players, viz Establishment Secretary and the Public Service Commission.
- The recruitment process is under-funded.

- Delays in inviting candidates for interviews make the most qualified candidates find employment elsewhere.
- The Ministry's Human Resource section is under manned.

3.8 Performance Management

A/ *Registration*

All practicing health personnel must legally be registered by relevant professional council to ensure that only those with appropriate qualifications can practice. This requirement was designed to ensure that medical practitioners adhere to the ethics of their profession and maintain standards.

There is evidence that a number of unregistered health professionals are currently practising. For instance, there is no CHO Registration Board. The health personnel training schools do not have an organised mechanism for curriculum review and development. The Registration Bodies in most countries are the vehicle for this activity.

B/ *Job Descriptions*

The MOHS Personnel officer is in possession of all job descriptions that can be used for any management innovation. Key result areas and reporting lines are well articulated albeit without job steps (grades).

C/ Performance Appraisal

Managers at various MOHS levels use annual **confidential reports** to assess staff performance. Confidential reports have many weaknesses amongst them, lack of objectivity due to lack of transparency. It is understood that the Government is considering introducing open performance appraisal.

It is important that an open staff appraisal system is introduced for it is less subjective and performance is assessed based on task targets set between the employee and supervisor. Such a system provides continuous monitoring of achievements and weaknesses; in the process, on-the-job training is offered to enhance individual and organisational capabilities. It also helps to build trust between employees and supervisors, assist in succession planning as well as creates transparency and accountability in determination of rewards including promotions.

D/ Supervision

Supervision from the MOHS Headquarters to the Districts and Chiefdoms is irregular and, whenever such supervision is undertaken, no clear mechanisms for checking organisational and individual performance exist.

In contrast, supervision from District Health Offices (DHO) by the DHMT to the Chiefdoms is guided by well articulated activity check lists.

3.9 Personnel Information

The MOHS currently has a **manual personnel information system** with two registries handling in-coming and out-going mail. Every MOHS employee has a personal file at MOHS headquarters, kept in the personnel registry under the personnel officer. The district stations/facilities where employees work do not keep duplicate personal files. The Establishment Secretary is the official custodian of personnel files in the public service.

3.10 Personnel Management

The Establishment Secretary is responsible for formulation of policies and procedures on conditions of service. The policies relate to retirements, training, recruitment, employee relations etc. However, government has decentralised some of the operational activities to line Ministries/Departments to reduce bureaucratic delays for improved performance.

The government provides some incentives and benefits in order to attract people to join government services. Some of them are provision of housing, education, and leave. However, housing is still a major problem in rural areas.

Retirement conditions are a prerogative of the Establishment Secretary. There are several conditions under which a civil servant may retire i.e.

1. 60 years of age pensionable service
2. Medical Grounds
3. Public interest
4. redundancy
5. Abolition of post or office.

Government offer special contracts to medical officers whose services are still wanted after reaching the mandatory retirement age.

3.11 Career Retention and Progression

Job satisfaction and motivation are major contributions to job performance and retention. Costs incurred to increase employee satisfaction and reduce attrition can be more than offset by the consequent improvement in performance and reduction in the cost of training replacements.

Promotion is very difficult due to narrow career paths. The nursing service personnel have remained in same position for years. There are some jobs which do not have schemes of service. Table 20 shows jobs in MOHS with schemes of service and those without.

Career planning is the Establishment Secretary's prerogative. The concerned Ministry/Department initiates and develops the scheme of service for the approval of the Establishment Secretary. At the moment the Establishment Secretary is considering a review of jobs and job grades in the public service (Job Evaluations programme) which includes MOHS personnel.

Table 19: JOBS WITH SALARY GRADES, SCHEMES OF SERVICE AND THOSE WITHOUT

NO	POST	S.O.S Available	NO S.O.S	Salary Grade
1	Consultant	√		14
2	Senior Specialist	√		13
3	Specialist	√		12
4	Senior Registrar	√		10
5	Medical Officer	√		9
6	House Officer	√		9
7	Scientific Officer	√		7
8	Chief Community Health Officer	√		10
9	Principal Community House Officer	√		8
10	Senior Community Health Officer	√		6
11	Community Health Officer	√		5
12	Director of Nursing Services	√		12
13	Nursing Sister	√		7
14	Home Sister	√		7
15	Senior Midwifery Sister	√		7
16	Midwifery Sister	√		6
17	Staff Nurse	√		5
18	Registrar of Nurses	√		7
19	Senior Lab. Superintendent	√		6
20	Student Lab. Technician	√		2

21	Chief Health Superintendent	√		10
22	Deputy Chief Health Superintendent		√	
23	Principal Health Officer		√	
24	Senior Health Superintendent	√		7
25	Health Superintendent	√		6
26	Public Health Inspector	√		5
27	Assistant Public Health Inspector	√		4
28	Public Health Aide	√		2
29	Nursing Aide	√		1
30	MCH Aide	√		1
31	Refractionist		√	
32	Optical Technician		√	
33	Mobile Projectionist	√		3
34	M&E Clerk	√		2
35	M&E Officer	√		4
36	Senior M&E Officer	√		7
37	Principal M&E Officer	√		8
38	Artist	√		3
39	Medical Demographer	√		7
40	Medical Photographer	√		5
41	Ward Officer	√		6
42	Senior Ward Officer	√		6
43	Staff Midwife	√		5
44	Principal Health Sister	√		8
45	Senior Health Sister	√		7
46	Health Sister	√		7
47	Food and Nutrition Manager	√		11
48	Pharmacist	√		7
49	Senior Pharmacist	√		8
50	Registrar of Births & Deaths	√		4
51	Senior Registrar of Births & Deaths	√		5
52	Principal Registrar of Births & Deaths	√		6
53	Deputy Chief Registrar of Births and deaths	√		8
54	Registrar of Pharmacy Board	√		11
55	Director of Drugs & Medical Supplies	√		12
56	Director of Primary Health Care	√		13
57	Director of Hospital & Laboratory Services	√		13
58	Pharmacy Technician	√		5
59	Chief Medical Electronic Engineer	√		12
60	Principal Medical Electronic	√		11

	Engineer			
61	Senior Medical Electronic Engineer	√		10
62	Medical Electronic Engineer	√		9
63	Pupil Electronic Engineer	√		7
64	Chief Medical Equipment Technician	√		9
65	Supt. Medical Equipment Technician	√		8
66	Senior Medical Equipment Technician	√		7
67	Medical Equipment Technician	√		6
68	Trainee Medical Equipment Technician	√		4
69	Principal Paramedical School	√		13
70	Principal National School of Nursing	√		10
71	Principal Midwifery School	√		10
72	Rehabilitation Worker		√	
73	Physiotherapist Assistant		√	
74	Physiotherapist	√		5
75	Senior Physiotherapist	√		**8**
76	Tutor	√		**7**
77	Senior Tutor	√		
78	SECHN 111	√		3
79	SECHN 11	√		4
80	SECHN 1	√		5
81	EDCU Assistant 111	√		2
82	EDCU Assistant 11	√		3
83	EDCU Assistant 1	√		4
84	Ophthalmic Nurse	√		5
85	Medical Statistical Assistant	√		**4**
86	Senior Medical Statistical Assistant	√		5
87	Medical Statistical Asst. in Training		√	
88	Medical Statistician	√		**7**
89	Senior Medical Statistician	√		8
90	Manager, Public Health & Medical Statistics		√	
91	Medical Statistician Assistant	√		**4**
92	Hospital Secretary	√		5
93	Senior Hospital Secretary	√		7
94	Principal Hospital Secretary	√		9
95	Hospital Manager	√		
96	Sanitary Engineer	√		7
97	Senior Sanitary Engineer	√		9
98	Principal Sanitary Engineer	√		10

99	Epidemiological Assistant in Training		√	
100	Epidemiological Assistant	√		**5**
101	Senior Epidemiological Assistant	√		9
102	Principal Epidemiological Assistant	√		10
103	Home Warden	√		1
104	Catering Officer	√		5
105	Assistant Catering Officer	√		4
106	Motor Mechanic	√		2
107	Ophthalmic Medical Assistant		√	
108	Clinical Instructor	√		7
109	Nutritionist	√		8
110	Assistant Nutritionist	√		5/7
111	Senior Nutritionist	√		9
112	Health Education Manager	√		
113	Health Education Officer	√		7
114	Senior Health Education Officer	√		8
115	Assistant Health Education Officer	√		5
116	Medical Entomologist	√		7
117	Senior Medical Entomologist	√		8
118	Principal Medical Entomologist	√		9
119	Chief Medical Entomologist	√		10
120	Medical Entomologist Assistant	√		
121	Limb fitter in training	√		2
122	Senior Limb Fitter	√		9
123	Limb Fitter	√		4-6
124	Limb Fitting Technician		√	
125	Senior Limb Fitting Technician		√	
126	Dental Receptionist	√		1
127	Dental Technician	√		5
128	Senior Dental Technician	√		8
129	Dental Hygienist	√		5
130	Leprosy control Officer	√		5
131	Leprosy Control Assistant	√		3
132	Dental Nurse	√		6
133	Hospital Records Technician	√		5
134	Senior Hospital Records Technician	√		6
135	Medical Records Technician	√		3
136	Senior Medical Records Technician	√		4
137	Environmental Health Manager	√		
138	Electrician	√		2
139	Mechanical Engineer	√		7
140	Vector Controller	√		1

141	Dispenser 1	√		4
	Dispenser 11	√		5
142	Senior Dispenser	√		5
143	Dispensary Attendant	√		1
144	Mental Attendant	√		1
145	Mortuary Attendant	√		1
146	Nurse Anaesthetist	√		6
147	Anaesthetist(specialist Medical doctor)	√		12
148	Radiographer	√		5
149	Senior Radiographer	√		6
150	Chief Radiographer	√		9
151	Senior Planning Officer		√	
152	Store Keeper 1	√		5
	Store Keeper 11	√		4
153	Forensic Analyst	√		10
154	Chiropodist	√		5
155	Senior Chiropodist	√		6
156	Librarian	√		7
158	Surgical Assistant	√		5
159	Senior Surgical Assistant	√		6
160	Chief Surgical Assistant	√		9
161	Caterer	√		1
162	Sewing Maid/Tailor	√		1
163	Infectious Disease Nurse	√		3

Source: Personnel Office, MOHS, July 2004

3.12 Employee Relations

Some health service personnel are members of the Public Service Trade Union. They may also be members of professional associations such as the Medical Association, the Nursing Association.

3.13 Current Staffing problems

Chronic shortage of appropriately trained human resources and poor distribution of existing staff stifle efforts to make health services accessible to all. A review of staffing situation in the last chapter highlights a number of problems which aggravate the generally known staff shortage in many key areas. Some of these problems are reviewed below:

- **Lack of Key Staff Categories**

  There are a number of facilities at all levels which do not have radiographers. Most provincial hospitals do not have the relevant range of specialists to undertake their referral function. Their absence does not only compromise the service at the provincial hospitals but also affects district hospitals and rural health centres which depend on provincial hospitals for supervision and support.

- **Lack of Deployment Policy**

  The MOHS establishment is lumped and staff are allocated to different facilities from a central pool. This system apparently enables the staff to accept or not accept postings.

  When a posting is done, some staffing members seem not to understand that they have to function from their posting location as the establishment is centralised and lumped.

- **Failure to match the health workers placement with their training**

  Large numbers of State Enrolled Community Health nurses (SECHN) are now based in hospitals. Most Environmental Health Officers are in Urban Western Area. Training and job descriptions of these two cadres clearly state that they are Community based Primary Health Care workers. Failure to remain in their designated places of work will mean that no amount in increasing the numbers will ever achieve any targets set.

- **Public/Private employment of Health Personnel**

  The private sector is absorbing staff from the public sector in an unscrupulous manner. Most health personnel working in NGOs have absconded from government service. This makes the already stagnant staffing situation more difficult to manage and impedes the delivery of quality care in MOHS facilities. Remedies should be sought.

- **The Age Distribution of MOHS Personnel**

  Almost a quarter of trained health workers should be retiring in the next five years. This means both basic and post-basic training should increase.

- **Geographical Distribution of Health Personnel**

  Most health personnel are in the urban centres especially Western Area. A number of reasons are given for this situation. Staff quarters and lack of social amenities in rural areas are just some of the reasons.

- **Untimely absorption of Health Personnel by MOHS**

  Most personnel have found their way to NGOs and private sector as a result of lengthy time it takes to get employed by government. There are some personnel serving in government facilities who do not get paid at the end of the month. There are some MOHS personnel who receive monthly salaries not concomitant with their salary grades.

- **Job titles and training**

  There are a range of workers who are either not properly titled or ignorant of their titles. In most cases job titles are not in line with the job one performs and training certificate one may possess. For instance most pharmacy technicians are called Pharmacists. There is need to rationalise jobs, job titles, and training.

- **Inadequate Careers**

  Promotions are rare in MOHS. This is due to limited, narrow and unclear career paths and opportunities. This is more so in the nursing section of MOHS.

- **Globalisation of Health Care Professional Labour market**

  The health care labour market has been internationalised creating staffing shortage in MOHS as highly skilled health professionals leave as a result of push and pull factors. Medical doctors and professional nursing services have been highly affected by this problem.

- **Inadequate Management Skills**

  There are a lot of managers in MOHS at all levels of care that do not possess management skills and the means of management.

CHAPTER 4

WORKFORCE SUPPLY FROM TRAINING

The shortfall in the numbers of health workers necessary to Sierra Leone's national health goal can be met in four ways: training within Sierra Leone through local institutions; training outside Sierra Leone; recruitment or upgrading of already trained health workers; and recruitment and deployment of expatriates.

4.1 Training Policies

There are no specific training policies for the health sector as a whole or the MOHS.

4.2 Training Responsibilities

The various professional councils are in-charge of service quality control. In most countries they have to approve the curricula for various training in their respective countries. This is not the case in Sierra Leone. Professional councils do not approve curricula for training.

There is no single body with responsibility for co-ordinating training within the overall health Sector. The MOHS has a Training Committee. It is generally responsible for external training affairs for MOHS.

4.3 Recruitment, Selection, Retention and Employment

Potential students apply for places at the training institutions of their choice. There are minimum entry requirements. Basic students write entrance examinations as part of the selection process.

The government is under no obligation to provide employment following successful completion of training. Likewise there is no bonding arrangement for students, who are paid tuition by government. In practice in most health worker categories, graduates may currently be assured of a job in government health service due to the current staff shortage.

4.4 Training providers in Sierra Leone

Two types of training are provided: **basic and post basic** (which incorporates external and in-service training)

A/ Basic Training

Basic training is delivered through an array of institutions within the Ministry of Education, Science and Technology (MOEST), the MOHS, and the catholic Mission also provides some basic training (see Table 20).

Table 20: Basic Training Provided in Sierra Leone for the Health Staff

Institution	Course	Duration (year)	Annual intake	NO. of full time tutors	Annual average output	% Dropout Rate
National School of Nursing (MOHS)	State Registered Nurse (SRN)	3	50	6	47	6
	State Enrolled Community Health Nurse (SECHN)	2.5	40	6	38	5
College of Medicine and Allied Health Sciences (MOEST)	Bachelor of Pharmacy	6	10	N/A	7	30
	• Bachelor of Medicine, Bachelor of Surgery	7	40	18	25	62.5
	• BSC Nursing	2	10	1	10	0
Pharmacy Technician School (MOHS)	Certificate Pharmacy	3	25	None	25	0
Paramedical School (MOHS)	Certificate Community Health Officer	3	30		25	17
School of Hygiene (MOHS)	Diploma Environmental Health	3	20		20	0
Nixon Memorial School of Nursing(SL Methodist Church School)	State Enrolled Community Nurse	2 ½	30	N/A	30	0
Mattru School of Nursing(UBC Mission School)	State Enrolled Community Nurse	2 ½	33	N/A	33	0
Eastern Polytechnic School of nursing	State Enrolled Community Nurse	2.5	30	N/A	30	0

Source: Training School Survey, January 2003, MOHS

Student dropout rates are high for most programmes but not all (varying between 0% to 62.5%). The reasons varied from difficulties in meeting academic standards to opting for studies abroad. The following problems are affecting the operations of basic training schools:

- Insufficient teaching aids;
- Inadequate library facilities;
- Lack of refresher training for tutors;
- Inadequate transport for student supervision during internship;
- Lack of electricity/water;
- Inadequate communication facilities;
- Tutor shortage: almost all schools are experiencing difficulties in providing qualified tutors. There are significant variations in the desired ratio of tutors to students through out the basic training schools. Tutor shortage is a significant factor in under-utilisation of the potential training capacity. It can negatively affect the quality of output and services.
- Some schools do not have their own buildings; and
- Inadequate funding which normally arrives late.

Dentist/Dental Technicians/ Therapist, Radiographers/ Technicians, Ophthalmologist/ Technicians/ Assistants, Physiotherapist/Assistants, are not trained within the country and they are very few in-post at the moment. This is creating problems of staff-skill mix and subsequently may reduce the quality of services offered.

There used to be a school for Laboratory Technicians but it folded up in 1983. Laboratory technician training is to re-start under the College of Medicine and Allied Health Sciencies in 2005/2006 academic year.

There is a parliamentary Act which has shifted the responsibility of Health personnel training schools from the MOHS to Ministry of Education Science and Technology under the Tertiary Education Commission.

Training of MCH Aides

MCH Aides training commenced in 1978 to promote mother and child health as well as increase access of midwifery services to pregnant mothers within communities as there is a huge shortage of professional midwives. There are six training centres with each serving two districts and these are:-

- Port Loko centre for Kambia and Port Loko districts;
- Bombali centre for Koinadugu and Bombali districts;
- Tonkolili centre for Kono and Tonkolili districts;
- Kanema centre for Kailahun and Kanema districts;
- Bo centre for Pujehuni and Bo districts; and
- Western area centre for urban and rural western area.

For each training centre there is a coordinator. Facilitators of MCH aid training are experienced midwives, CHOs and specialists in various areas such as environmental health, community health, nutrition, EPI etc. Training consists of 18 months theory and 6 months practical. Thirty (30) is the number allocated for each district every two years.

MCH aid training is facing a range of problems which include:-

- inadequate funding hence training not conducted every two years as planned;
- Inadequate logistics which include transport; and
- Obsolete training manuals which need updating.

B/ Post-Basic Training

Post basic training is one of two types:

- In-service training provided at service centres within Sierra Leone
- Advanced training provided through educational institutions in Sierra Leone, or more frequently through donor-sponsored training and institutions elsewhere.

Table 21 - Post-Basic Training Provided within Sierra Leone

Institution	Course	Duration	Annual Intake	No. of full time tutors	Annual Average Output	% Dropout
College of Medicine and Allied Health Sciences	Certificate in Tropical Medicine and Health	3 months	30	5	30	0
College of Medicine and Allied Health Sciences	Diploma in Community Medicine and Health	9 months	25	5	25	0
College of Medicine and Allied Health Sciences	Masters of Science (MSC) in Community Health	2 years	2	5	2	0
National School of Midwifery	State Certified Midwifery	18 months	40	1	30	25

Source: Training School Survey, January 2003, MOHS

The problems of post-basic training schools in Sierra Leone are as follows:

- Lack of infrastructure and teaching aids: staff/student accommodation, classroom space, laboratories, books etc.
- Tutor shortage: the tutor/student ratios speak a lot about the situation. In the nursing schools, such as the National School of Midwifery, it is as high as 1:40
- Poor conditions of service for staff: low salaries and poor career structure.
- Lack of transport for students to take them to practical sites.
- Inadequate funding, which comes late.

The HR division in the MOHS does not have the capacity to co-ordinate training and assess training needs. Each functional area consequently manages its own post-basic training. In short, the processes for managing this aspect of staff and organisational development are not yet functioning adequately.

The outcome is, not unexpectedly, training driven primarily by individual interest and initiative with little post-training mobilisation of the acquired skills, directed at improving the performance of the institution from which the staff comes

This aspect of staff training will become increasingly important not only for raising the general skill levels of the workforce, but perhaps more importantly in light of the current levels of pre-retirement losses in the workforce, as a mechanism for providing skills necessary for ensuring a succession of adequate staff to fill higher level vacancies.

C/ In-Service Training

In service training is mostly conducted at service provision centres and the heads of various sections plan their own in-service training. Institutions do not have a line item in their budget for in-service training. Most of the in-service training currently being carried out is funded by development partners. There is no co-ordination of in service training for MOHS staff at national level.

D/ Training Abroad

For other health training fields that are currently not available within Sierra Leone, the MOHS sends serving officers for studies abroad. Although the Sierra Leone government sponsors some students, it is dependent on development partners for the majority of scholarships. Major areas of study include, among others specialisations in internal Medicine, Public Health, Nursing, Health Policy and Planning, Hospital Management and other fields. Table 22 below shows number of MOHS personnel currently in training abroad.

Table 22: Number of MOHS Personnel Training Abroad on long term Training

Staff Category	Country of Training	Number in Training	Area of study
Medical doctor	England	4	Public health
Medical doctor	Egypt	1	Orthopaedic Surgery
Medical doctor	Ghana	1	Cardiology
Medical doctor	South Africa	1	Radiology
Medical doctor	Zimbabwe	1	Internal Medicine
SRN	South Africa	1	Midwifery
SRN	Ghana	1	Nurse Tutor's Course

Source: MOHS HR Manager Office, July 2004

The MOHS has a budgetary line item for training. This budget largely caters for external training. It is small as compared to the post-basic training requirements of the MOHS. It is worth mentioning that personnel who have the opportunity to train overseas are tempted not to return and work in Sierra Leone.

Table 23 - DISTRIBUTION OF CORE CADRE BY POST BASIC QUALIFICATION IN MOHS

BASIC QUALIFICATION	TOTAL	NUMBER WITH NO POST BASIC QUALIFICATION	POST BASIC QUALIFICATION
B.Sc	**2**	1	2
B Pharm	**12**	11	1
B.Sc Biochemist	**1**	0	1
CHO Cert.	**132**	116	16
MCH Cert.	**1023**	1023	0
X-Ray Tech. Cert.	**2**	2	0
Druggist Cert.	**66**	66	0
EDC Cert.	**247**	240	7
Lab Tech Cert.	**51**	51	0
SECHN/SEN	**653**	474	179
Vector Control Cert.	**2**	0	2
Dental Tech Cert.	**4**	4	0
Optical Cert.	**4**	4	0
Orthopaedic Cert.	**4**	4	0
SRN	**309**	112	197
City and Guilds	**1**	1	0
Civil Service	**1**	0	1
RSH Conf. Exam (EHO Training)	**4**	2	2
Dip RSH (EHO Training)	**104**	65	39
Dip Radiography	**2**	2	0
HND	**9**	6	3
HTC	**1**	0	1
MD	**125**	71	54
MSc	**6**	3	3
OMA	**1**	0	1
P&O	**1**	1	0
SND	**2**	2	0

Source MOHS HRD Survey, July 2004

Table 24 above shows the number of people with post basic training in MOHS. Personnel numbers with post basic training is small. There are some cadres which are pertinent but missing on MOHS staff list because of their unavailability. These personnel include orthopaedic nurses, intensive care nurses etc. The training of these types of personnel is not available in Sierra Leone. Post basic training needs to be properly funded and prioritized.

There are several problems with the management of post-basic training currently and these include:

- Most of the external specialised training offered by the MOHS is generally driven by individual requests, rather than by analysis of organisational requirements;
- Lack of training plans or policies; and
- Utilisation of trained personnel often does not correspond to their particular skills training.

CHAPTER 5

Analysis of the Situation

5.1 Introduction

The stock numbers of some medical and paramedical staff have been obtained by means of a stock and flow calculation based on annual outputs from basic health personnel training schools, expected dropouts and wastage. The figures in the graduating column constitute achievable targets each year within the current training capacity in Sierra Leone health personnel training schools. The current training stock column reflects the in-post personnel in the entire health sector. Several assumptions have been made as listed below:-

- Population growth remaining constant during the plan period;
- Funding for health services in particular personnel emoluments will increase;
- Wastage rates remain constant across the entire sector;
- Student intakes and outputs remain constant; and
- Student dropout rate remain constant.

This projection method does not consider the supervisory relationships of various cadres.

5.2 Projected staffing requirements

The vacancies in Tables 7, 8 and Annex 1 are the future requirements. These requirements are the currently known. The desired future with regard to health personnel might be defined not just in terms of increasing the existing stock of health workers to meet the currently existing demand in terms of staffing standards and the non-operational health facilities. The aim should also be to decrease the ratio between health worker and population, which will of course be increasing.

5.3 Currently unclear requirements

Whilst the requirements in Tables 7, 8 and Annex 1 represent the factors about which there is reasonable certainty, there are a number of important areas where the future is unclear.

5.4 Requirements of other care providers

It has not been possible to identify the requirements of health care providers other than MOHS. These other health care providers include other government departments, NGOs, religious health services and the private sector.

5.5 Projection of Health Personnel Stock for the Sector in 5 years

Below is the supply driven stock and flow projection. The stock numbers are those for MOHS only. The training output is that of health personnel schools within Sierra Leone. The number of SECHN is a total of Nixon, Mattru, the National school of Nursing and Eastern Polytechnic.

Table 25 - STOCK AND FLOW FOR 2004

STAFF CATEGORY	IN-POST	INTAKE YEAR	INTAKE No.	DROPOUT RATE	GRADUATED	WASTAGE RATE	WASTAGE NUMBERS	STOCK
Medical Officer	112	1998	40	62 ½ %	16	20%	22	108
CHO	170	2002	30	17%	25	10%	17	178
EHO	117	2002	20	0	20	5%	6	131
SRN	173	2002	50	6%	47	20%	34	186
SECHN	969	2002	131	5%	124	10%	97	996
Pharmacy Tech.	256	2002	25	0	25	0	0	281
SCM	242	2003	40	25%	30	20%	48	224

Table 26 - STOCK AND FLOW FOR 2005

STAFF CATEGORY	IN-POST	INTAKE YEAR	INTAKE No.	DROPOUT RATE	GRADUATED	WASTAGE RATE	WASTAGE NUMBERS	STOCK
Medical Officer	106	1999	40	62 ½ %	16	20%	21	101
CHO	178	2003	30	17%	25	10%	18	185
EHO	131	2003	20	0	20	5%	7	144
SRN	186	2003	50	6%	47	20%	37	296
SECHN	996	2003	131	5%	124	10%	97	1,023
Pharmacy Tech.	281	2003	25	0	25	0	0	306
SCM	224	2004	40	25%	30	20%	45	209

Table 27 - STOCK AND FLOW FOR 2006

STAFF CATEGORY	IN-POST	INTAKE YEAR	INTAKE No.	DROPOUT RATE	GRADUATED	WASTAGE RATE	WASTAGE NUMBERS	STOCK
Medical Officer	101	2000	40	62 ½ %	16	20%	20	97
CHO	187	2004	30	17%	25	10%	19	193
EHO	144	2004	20	0	20	5%	7	157
SRN	296	2004	50	6%	47	20%	59	284
SECHN	1023	2004	131	5%	124	10%	102	1045
Pharmacy Tech.	306	2004	25	0	25	0	0	331
SCM	209	2005	40	25%	30	20%	42	197

Table 28 - STOCK AND FLOW FOR 2007

STAFF CATEGORY	IN-POST	INTAKE YEAR	INTAKE No.	DROPOUT RATE	GRADUATED	WASTAGE RATE	WASTAGE NUMBERS	STOCK
Medical Officer	97	2001	40	62 ½%	16	20%	19	94
CHO	193	2005	30	17%	25	10%	19	199
EHO	157	2005	20	0	20	5%	8	169
SRN	284	2005	50	6%	47	20%	57	274
SECHN	1045	2005	131	5%	124	10%	104	1065
Pharmacy Tech.	331	2005	25	0	25	0	0	356
SCM	197	2006	40	25%	30	20%	31	188

Table 29 -STOCK AND FLOW FOR 2008

STAFF CATEGORY	IN-POST	INTAKE YEAR	INTAKE No.	DROPOUT RATE	GRADUATED	WASTAGE RATE	WASTAGE NUMBERS	STOCK
Medical Officer	94	2002	40	62 ½ %	16	20%	19	91
CHO	199	2006	30	17%	25	10%	20	204
EHO	169	2006	20	0	20	5%	8	181
SRN	274	2006	50	6%	47	20%	55	266
SECHN	1065	2006	131	5%	124	10%	107	1082
Pharmacy Tech.	356	2006	25	0	25	0	0	381
SCM	188	2007	40	25%	30	20%	38	180

5.6 Mismatches

The projection shows that, except for SRN, SCM and medical officers, other cadres trained in Sierra Leone will be adequate in so far they are recruited by government and properly deployed. It is however obvious that if non-functioning facilities and population growth are considered all the requirements will not be met during the plan period.

Mismatches between supply and demand will differ from one group to another. It is important to explore ways of minimising the mismatches, in particular in those areas where mismatches can be influenced or managed. Priority must then be given to those areas which will have the greatest impact on the provision of health services.

There are four main strategies for resolving the mismatches which are all concerned with quantitative shortfalls and these are listed below:-

1. Reduce wastage of existing staff
2. Increase productivity of existing staff (which could lead to reduced requirements)
3. Increase input by recruiting and training new staff
4. Restructure the way in which services are provided and staffed.

It is important to note that the projection above considers requirements that can be met by basic training only. Post-basic training requirements are not considered. Post basic projections can be obtained from the staff strength analysis.

5.6.1 Qualitative Aspects

Though the focus of the plan is on an increase in the quantity of staff, there are qualitative aspects of the future workforce, some of which will influence productivity, to be considered.

5.6.2 Performance Management

The investment in increasing the numbers of personnel in priority areas will only pay off if ways of helping those members of staff to contribute effectively to the National Health Policy can be developed and implemented. A reduction in the absence from the workplace would go some way to meet the current perceived staffing shortfall. There is also no effective system for overseeing the amount of and the quality of work produced by staff, and linking training and development requirements to the needs of the individual's job.

There is therefore a need to develop systems to reduce absence from the workplace and systems that support the carrying out of quality work in line with the planned delivery of services.

5.6.3 The Quality of Training

To make up for the large shortfalls of health personnel there is great pressure on the current training system. It is therefore essential that the current quality of training is not degraded as a result of increased training load. Measures are therefore required to improve the upgrading of physical facilities and training related equipment and logistics and the quality of training by providing trainers with continuing professional development opportunities.

5.6.4 The Management of Change

At times of reform the uncertainty is not only experienced by planners and managers, but also by the workforce as a whole. Members of staff will be anxious about changes to their jobs, and in particular, to their types of employment and conditions of service. The process of decentralisation to local government will affect many MOHS workers. The move to semi-autonomous status of hospitals will also affect a large number of employees.

Experience elsewhere has shown that where the workforce has been neglected in change process, staff morale and consequently productivity has dropped.

Much needed health professionals have resigned, and in some cases serious industrial action has been taken with the support of hitherto dormant unions. Much could be learnt from reviewing the experiences of other countries that have undergone decentralisation, especially those that have decentralized to local government.

It is therefore essential that at this early stage of reform process the current systems of communication between management and staff are reviewed, and that effective strategies, both short-term and long-term for managing the change process, are developed. In the case of decentralisation to local government these should be developed jointly by MOHS and MOLGD (Ministry of Local Government and Rural Development).

Most of the detailed planning and the majority of the management of the personnel will take place at decentralised levels. Both the human resource planning and management systems and the capacity to operate them must be developed at these levels. The MOHS will provide or will be required to provide technical assistance in human resource planning and management on a 'consultancy' basis to decentralised levels.

Decentralisation will mean that all employees at Primary Health Units will become the responsibility of the District Assemblies. There will also be a need to manage the transition of the employment of health personnel by the District Assemblies and to develop appropriate human resource management systems both at district and national level. Table 30 describes the projected situation by the end of the plan period and some of the logical strategies assumed necessary to achieve this situation.

Table 30 - HR STRATEGIES NEEDED TO SUPPORT DECENTRALISATION

CURRENT SITUATION 2004		HR STRATEGIES/ISSUES FOR TRANSITION		FUTURE SITUATION BY 2008
MOHS HQ Functions: Policy, standards, management of delivery of services Management structure		• Capacity building to take on new roles • Reallocation/ Retrenchment		**MOHS HQ Functions:** • Policy • Standard setting • Regulation • Advisory • International Cooperation Linkage • Central Level Inter-sectoral Collaboration **Management structure:** • Shift from management to advisory **Staffing:** reduced number
Tertiary Hospitals **Functions:** • Provision of tertiary care		• Establish HR system to support semi-autonomy and delink systems from		**Tertiary Hospitals** **Functions:** • Provision of tertiary care

• Training sites **Management structure:** All controlled by MOHS		Central govt (e.g. PSC) • Strengthen management capacity (personnel, skills)		• Training sites **Management structure:** autonomous **Staffing: Improve Specialisation and Support**
District Hospital **Functions:** • Provision of secondary care • Referral to tertiary care **Management structure:** • Managed by DMO		• ?? Develop supervision and regular supervisory and regulatory capacity (personnel, skills) • Develop self-management capacity (personnel, skills, including planning, budgeting, implementation monitoring evaluation and reporting)		**District Hospital** **Functions:** • Provision of secondary care • Referral to tertiary care • Technical supervision and regulation of primary care service on behalf of MOHS **Management structure:** Semi-autonomous • Stronger self-management **Staffing:** stronger top management
District Health Office/Team: **Functions:** • Planning and management of hospital and primary care services • Personnel management • Accounting • Purchasing • Collection and analysis of monitoring data **Management structure:** Management by MOHS		• **Prepare staff for change:** - inform about options - inform about new conditions of service		**Autonomous:** • ?? Planning and management services • Personnel management including recruitment • Accounting • Purchasing • Collection and analysis of monitoring data • Environmental health services **Management structure:** Management by hospital board;
Sub-district facilities (MOHS - health centre, health posts) • Provision of primary care service and referral **Management structure:** Managed by district assemblies		• **Prepare staff for change:** - inform about options - inform about new conditions of service • Recruit staff to DAs • Prepare for different management structure (technical supervision by Dist. Hosp.; management supervision by District Assemblies		**Sub-district facilities:** (health centre, health posts, dispensaries, maternity clinics; environmental health) Functions: • Provision of primary care service and referral • ??environmental health **Management structure:** Managed by District Assembly

CHAPTER 6

THE HEALTH SECTOR HUMAN RESOURCES DEVELOPMENT PLAN 2004 - 2008

6.1 Overview

Purpose

The guiding principle in constructing the Human Resource Development Plan is that it should support the implementation of the National Health Policy. The overall purpose to be achieved during the plan period is therefore: adequate and equitable distribution of appropriately trained and effective staff to provide planned health services in Sierra Leone.

Outputs

To achieve this purpose, the following outputs need to be achieved during the plan period:

1. The capacity to maintain staffing level in line with service needs
2. Training and development in line with staffing requirements as specified in the Human Resource Plan.
3. Effective and targeted staff retention measures developed.
4. Effective personnel management systems established.
5. Effective management of the change process (the public sector and health reforms) implemented.

Activities

Each of these outputs has its associated activities. Given the current level of uncertainty regarding the exact nature of the reforms and the detailed staffing requirements to support the National Health Policy, the activities required to achieve the outputs may need to be adjusted within the duration of the plan period. Activities have been assigned to each output based on the best available information. The proposed activities should be reviewed continuously, and modified as necessary to achieve the associated output.

Whilst the plan relates to all health sector personnel, certain priorities have been set in relation to specific staff groups, institutional levels and locations. These priority areas are indicated in the plan by specific activities and/or targets.

An overview of the plan is presented in the form of logical framework at the beginning of document.

6.2 Details of the Plan

The activities of the plan are presented by output.

Output 1 - The capacity to maintain staffing levels in line with service needs

Having established the National Human Resource Development plan for the health sector, it is essential to develop a means of both implementing and updating it. As this is a plan for the whole sector, a sector-wide high level co-ordinating body should be strengthened to oversee this process.

A technical capacity needs to be developed to support the body. Systems are needed to provide the necessary monitoring information on the staffing situation and staffing needs.

The strengthening of the co-ordinating body, the technical support and the information systems is crucial to the success of the plan.

Activities

1. Agree targets for specified staff groups.
2. Strengthen Health Sector Human Resource Co-ordinating body.
3. Quarterly meetings of Health Sector Human Resource Advisory body.
4. Develop sector-wide health human resources policy.
5. Improve HR planning system; improve HR intelligence by reports & research.
6. Regular analysis of HR information.
7. Annual revision of 5-year rolling national HR plan.
8. Refine HR planning system.
9. Develop HR planning capacity (training and equipment)
    - Recruit analyst/statistician for HR Planning team.
    - Equip HR planning function.
    - Develop skills of HR Planning team.
    - Orientation for HR personnel of employing institutions to national planning system.

Output 2 - Training and Development Provision (pre-service and in-service) in line with staffing requirements as specified in the Human Resource plan

The highest priority of the plan is to rapidly expand the numbers of certain types of staff. This will mainly be achieved by increasing the labour pool of trained personnel, the emphasis with regard to training therefore, is to expand the output for certain staff groups. This requires more trainers, and in the short-term, the use of expatriate trainers. Quality of training which is already low in some cases must not be lost in the process of expansion. Quality is improved by providing continuing professional development for training personnel and upgrading facilities.

The reforms will require a much higher level of management at decentralised levels. In addition to this, MOHS staff will need to change roles from managers to advisors. Management development programmes are needed to support these changes. These may need to be "crash" programmes to get managers ready for the reforms, but later they will need to be consolidated to ensure that there is permanent support for this essential component of service provision.

As part of enabling staff to perform optimally, their skills need to be regularly upgraded. Because of the pressure on training institutions to provide basic training, imaginative forms of skill development must be used - for example the development of guidelines, manuals - and then supplemented by institution-based training programmes when initial training requirements have stabilised. Owing to the premium on staff time and on institutional capacity to provide training and development activities, co-ordinating systems will be developed to ensure that training and development opportunities are prioritised and provided to those who will make most use of the skill gained.

Activities

1. Increased production from basic training
    - Increase use of expatriate tutors
    - Improve retention of existing tutors and preceptors for targeted groups
    - Train additional tutors and preceptors for targeted groups
    - Reduce dropout rates for Nurses/medical doctors
    - Increase student intake for targeted groups
    - Review curricula for targeted groups
    - Restart/increase training outputs for laboratory Technicians
    - Start training medical assistants and community health assistants
    - Upgrade training facilities (equipment and buildings)
    - Provide continuing professional development (CPD) for tutors and preceptors
2. Management development programme established
3. Develop comprehensive in-service training and development programme

Output 3 - Effective and targeted staffing retention measures developed

Staff shortages will be reduced if the level of wastage through resignations and abscondments in certain staff groups can be stemmed. This will first require better understanding of the reasons for this wastage, and clarification of the destination of the leavers. If they are re-employed by other health providers in Sierra Leone, they are not a loss to the sector. It is of far greater concern if they move to other sectors or emigrate. There is a high loss amongst doctors and certain staff groups in the early years of their career. This needs special attention.

Retention of staff in rural areas is almost universally a problem. The policy of decentralisation to independent employers is of concern with regard to equity in the provision of services, as the better resourced employers are likely to attract staff away from areas where they are most needed. This situation needs to be carefully monitored. Experimentation with strategies for retaining staff is needed to inform policy. These experiments might include the use of any of the following:

- Rural incentives
- Ensure appropriate housing provision
- Better communication with management; increased involvement
- Bonding arrangements from initial/further training
- Career structures developed
- Alternative staffing structures.

In order for the strategies to increase retention to have any impact during the plan period, work to set up the experimentation must be started early on in the plan period.

Activities

1. Retention of staff in rural areas
   - Study on difficulties in retaining SECHNs and CHOs
   - Develop strategies
   - Seek funding
   - Pilot selected strategies
   - Review pilot experiences
   - Implement selected successful strategies

2. Retention of young staff in specific jobs

3. Retention of Doctors and Nurses at district level

Output 4 - Effective Personnel Management Systems developed

The management of staff is generally considered a simple area. Cumbersome staff management systems provide the perfect excuse for delaying or totally avoiding this essential management function. Simple, supportive personnel management systems are required- in the form of recruitment, performance management, supervision, personnel regulations, proper personnel records keeping and up-to date job descriptions. These systems take time to develop and install. Developing and implementing staff regulations is the first step to developing a work oriented culture. The public service has staff regulations which have not been revised to date to meet the current personnel management challenges. However, more positive and supportive systems need to be subsequently introduced as soon as possible.

The MOHS should go ahead with development of personnel management systems for its hospital institutions as MOHS will still retain control of these institutions under the hospital board act.

Activities

1. Work with the Establishment Secretary to make sure every MOHS personnel is on the payroll and work out permanent mechanisms for accelerated absorption of new entrants into the service.
2. Rationalise job titles and review job descriptions and make them available to post/job incumbents.
3. Improve the manual personnel records system/develop computer aided Personnel Records System.
4. Develop personnel regulations and provide orientation to managers.
5. Review staff schemes of service and develop where not available.
6. MOHS performance appraisal and supervision systems developed

- Clarify new management structures
- Design prototype performance appraisal and supervision systems
- Pilot systems in selected hospitals
- Review and modify systems
- Disseminate systems and provide orientation training to hospital managers

Output 5- Effective management of change process (the public sector and health reforms) implemented

As mentioned in the previous chapter the neglect of this area could have serious consequences for the effective implementation of the National Health Policy and the longer-term impact of the reforms. Urgent priority should be given to this work, but should be done in joint consultation between the MOHS and the MOLG

Activities

1. Develop short-term communications strategies
   - Conduct staff attitude survey
   - Review of experiences of similar form of decentralisation in other countries (literature search and or visit)
   - Develop short-term communication/consultation strategies
   - Approval
   - Implement short-term communication strategies
2. Develop sustainable communication systems
   - Review of current management-staff communication/consultation systems
   - Develop improved management-staff communication/consultation systems
   - Regularly identify key information re-changes to be communicated
3. Develop detailed plans and costings for changing of employment arrangements
   - Develop detailed costed implementation plan at least six months before the transition date
   - Communicate implementation plan to all staff not later than 3 months before the transition date

6.3 Strategies

Primary Health Care Group

Health care cadres providing primary health care are the District Medical Officers, Community Health Officers, Dispensing Technicians, Environmental Health Officers, State Enrolled Community Health Nurse, EDCU, Monitoring and Evaluation Officers, Health Education Officers, MCH aides, Entomologist, Nutritionist, Epidemiological assistants, Traditional Birth Attendants, Vaccinators, DOO, Motivators and focal persons.

1. District Medical Officers/Public health specialist

Situation

There are 19 qualified public health officers in the public health sector. There are 13 districts with district health offices. Only 7 District Health Officer have a minimum requirement of masters' degree in public health. Four (4) medical officers are currently overseas undergoing masters in public health programme. All public health programmes need to be headed by a doctor with a masters in public health. In total there is a deficit of thirty two (32) qualified public health officers with masters in public health to man the remaining district health offices and programmes.

Situation

- 20% attrition is optimistically assumed and this means the public health sector will be losing 4 qualified public health officers every year of the plan period. This shows that all qualified public health officers currently in post will be lost due to attrition.
- MOHS will have to train 51 qualified public health officers with a master degree in public health during the plan period.

Strategies

- Reduce attrition.
- Train 10 doctors in masters of public health every year of the plan period.
- Provide salaries relative to inflation and staff quarters.

2. **TBA'S**

The number of TBA's (trained) should be increased to 10,523 over the period of 5 years. There is need for basic refresher training of TBA's for clean and safe delivery and the identification or recognition of high risk groups for referrals. While it is argued that TBAs do not have a positive impact on infant and maternal mortality, Sierra Leone should maintain this cadre for the following reasons:-

a) Deliveries done by TBA's are higher than those of MCH-aides.
b) They capture a good part of the population due to social obligations.
c) They help in the collection of data.
d) They identify high risk groups for referrals.
e) Their roles as motivators help in EPI coverage.
f) TBAs remedy the situation in hard to reach areas.

3. **MCH – AIDES**

Strategies

a) More training centers should be established in each district.
b) The intake should be annual instead of bi-annual.
c) Each primary health care unit should have two-MCH-aides.
d) Training manuals need to be reviewed and updated to take cognizance of new concepts and practices.
e) Adequate funding should be provided for MCH aid training.
f) Quarters with toilet and light facilities should be provided.
g) Mobility and logistics should be provided to all MCH aides.
h) MCH Aids title should be changed to community midwives and their skills and syllabus should be upgraded.

i) A post training evaluation for MCH aids should be done as this has never been conducted since the programme started. This will help to determine the effectiveness of the programme.

4. Monitoring and Evaluation officers

Situation

There are 10 absorbed monitoring and evaluation officers who are based at MOHS headquarters. There is another 10 unabsorped monitoring and evaluation officers based at district health offices. Attrition in this group is assumed to be 0%.

Strategies

- Absorb all the 10 unabsorbed monitoring and evaluation officers.
- There should be two (2) monitoring and evaluation officers per district. This gives a total of 36.
- Recruit an additional 16 monitoring and evaluation officers.
- Train all monitoring and evaluation officers in their respective area of monitoring and evaluation in health services as well as computer training.
- Procure one desk-top computer for each district and 10 computers for headquarters Monitoring and Evaluation officers.

5. Environmental Health Officers (EHOs)

Situation

- There are currently 113 EHOs in MOHS service and 4 with other operating agencies.
- There is a total deficit of 52 at PHU level and 65 at district health office
- Zero attrition is optimistically assumed.
- It is now official that a new cadre known as Community Health Assistants to replace environmental health officers at PHU level will be created.

Strategies

- The training of EHOs should be continued.
- Train 65 more environmental health officers.
- If the target is substantially increased, concentrate on training more assistants at the expense of further Environmental Health Officer training.
- In any event, it would appear that the number of officers will exceed requirements in about 5 years time.
- The current ratio of environmental health officers to assistants is about 0 to 117. It may be worth reconsidering the ideal ratio between these two types of staff and taking this into account in the setting of targets.

6. Community Health Assistants

Current situation

- There are no Community Health Assistants in the MOHS currently.
- Their training will start in academic year 2005/2006
- There is nobody currently in training
- The target being sought is 256.
- An output of 50 per year if started 2005/2006 would achieve this target in 8 years time.

Strategies

- Develop their scheme of service and job descriptions.
- Get the blessing of a medical professional body.
- Commence a training programme in 2005/2006 academic year

7. Community Health Officers

Current Situation

- There are 170 CHO in MOHS and other providers
- There is a deficit of 95 at the PHU and 22 at the district totaling 117.
- This deficit can be achieved within the plan period
- Attrition is estimated at 10%

Strategies

- Timely absorption of new CHO graduates
- Increase the salary of CHOs
- Provide rural allowance
- Provide decent staffing quarters
- Minimize attrition

Nursing group

1. Registered Nurses

Current situation

- Current deficit is 770 in MOHS plus a 10% allowance of the current deficit in MOHS for private/NGO and unopened MOHS facilities totaling 884.
- Attrition continues at an underlying rate of 20%.
- Therefore the current requirement figure of 884 is unachievable under the current outputs and absorption rate.

Strategies

- Increase output from training

- Create mechanisms for fast absorption of nurse graduates. Thirty (30) currently unabsorbed registered nurses should be urgently absorbed
- There is need for in-service and refresher training for serving SRNs e.g. Management training and computer training.
- Nursing work require certain supplies and logistics which are currently inadequate. These supplies and logistics should be made available adequately. These include sterilizers, BP machines, scissors, antiseptic lotions etc.
- There is need for specialized nurse training at post graduate level so that hospital services have a range of nursing services. Each secondary and tertiary hospital should have the following specialized nurses 1 psychiatric nurse, 1 paediatric nurse, 1orthopaedic nurse and 1 public health nurse.
- Do everything to minimize wastage of existing staff by motivating them through provision of allowances such as remote, separation, risk and night allowances as well as proper staff quarters.
- Review the current SRN training manuals and curricula.
- All public health nurses should be given matron training.
- There is need to continue basic and refresher training of nurses, this will increase the number of trained and qualified nurses.
- Develop strategies to retain nurses such as promotion from one level to the other at least every four years taking into account qualifications. Salaries should be increased based on qualification and experience.
- Nursing careers should be properly planned by MOHS.

2. Staff midwives

Current situation

- Current deficit is 332 in MOHS plus a 10% allowance of the current deficit in MOHS for private/NGO and unopened MOHS facilities totaling 365.
- Attrition continues at an underlying rate of 20% across the sector.
- Training for staff midwives is dependent on the output of state registered nurses.
- There is only one tutor at the staff midwives school.

Strategies

- The deficit of 365 is unachievable in during the plan period at the current training output.
- Increase the number of tutors at the staff midwifery training school to four (4).
- Staff midwives should be properly deployed based on the needs of each part of the country's and job descriptions.
- There is need for in-service and refresher training at all levels for serving staff midwives e.g. Management training and computer training.

- Midwifery work requires certain supplies and logistics which are currently inadequate.
- There is need to minimize wastage of existing staff by motivating them through provision of allowances such as remote, separation, risk and, night allowances as well as proper staff quarters.
- Develop strategies to retain nurses such as promotion from one level to the other at least every four years taking into account qualifications. Salaries should be increased based on qualification and experience.
- Staff Midwifery careers should be properly planned by MOHS.

3. State Enrolled Community Health Nurse

Situation

- Current deficit is 839 in MOHS plus a10% allowance of the current deficit in MOHS for private/NGO and unopened MOHS facilities totaling 923.
- Attrition continues at an underlying rate of 10% across the sector.

Strategies

- The requirement of 923 will be met within the plan period at the current SECHN training schools output.
- There is an urgent need to absorb 128 SECHNs currently unabsorbed and put in mechanisms for faster absorption of new recruits.
- Minimize attrition at all cost.
- More tutors and adequate funding need to be made available for SECHN training schools.
- In future when there are adequate SRNs, SECHNs should be deployed in their areas of training i.e primary health care units.

Laboratory and Medical services group

1. Medical Officers/internal medicine specialists

- There is a deficit of 108 medical officers in MOHS and a 10 % allowance of MOHS deficit is assumed for private/NGO and other government hospitals to be built creating a total of 120. This figure should be doubled given that medical officers form the base pool for various medical specializations both in internal medicine and public health. This means the total number of medical officers needed is in the region of 240.
- Quite a high attrition rate of 20% has been assumed across the sector.
- The output for the next five years from MBBS to medical officers is determined purely by the numbers currently in training (as the course is 7

years long). The current level of output (16 a year) is not sufficient to meet the target in 5 years time.

- At current output there will be a shortfall of some 165 MOs at the end of the plan period.
- If the current output was 48 MOs a year and zero attrition then the target would be reached.
- The following internal medicine specializations are in large shortage as indicated by the corresponding requirement figures:

Physicians	–	16
Anesthetists	-	3
Pathologists	–	5
General Surgeon	-	15
Dental surgeons	-	9
Cardiologists	-	3
Radiologists	-	4
Pediatricians	-	6
Gynecologist/ obstetricians	-	3
Ophthalmologists	-	4
Psychiatrists	-	4

- It is apparent that various internal medicine specialization requirements cannot be achieved during the plan period.

Strategies

- Increase the output of MBBS training to 48.
- Reduce student dropout rate.
- There is need for fast absorption of MBBS graduates.
- There is need to prioritize training of internal medicine. Priorities are in this order Physicians, General Surgeon, Pediatricians, Gynecologist/ Obstetricians, Pathologist, Dental surgeon, Anesthetist, Radiologist, Ophthalmologist , Psychiatrist, and Cardiologist
- At least six (6) specialists should be coming out every year then half of the target would be met within the plan period.
- Minimize wastage of existing internal medicine specialist and medical officers by motivating them through provision of good salaries and allowances such as risk and, night allowances as well as proper staff quarters.

2. Medical Assistants

Situation

- Medical assistants are not currently trained in Sierra Leone.
- Medical officers are few and far apart and are concentrated in urban areas. They face heavy workloads. Training of medical doctors has long lead periods.

- There is need to create and train a medical assistant cadre to support medical officers.
- At least Ten (10) Medical Assistants per hospital.

Strategies

- Get the blessing of the medical and dental council.
- Develop the syllabus.
- Develop their scheme of service and job descriptions.
- Build teaching compus
- Medical Assistant training should be introduced at a significant level (at least an intake of 30 per year).
- Commence a training programme in 2005/2006 academic year.
- The training should last at least three years.
- Proper staff quarters should be built for this cadre.

3. Laboratory Technicians

Current situation

- Attrition is assumed 0%.
- There is a deficit of 20 laboratory technicians plus a 50% allowance of the deficit for the private/NGO/mission and upcoming government services which give a total of 30.
- A new laboratory technicians training programme is to start under COMAHS in year 2005/2006 academic year.
- The proposed intake is 20. The proposed duration is two years. Graduates will get a diploma.
- As the basic level is being upgraded to technician, Laboratory assistants currently in post need to be upgraded over the next five years.

Strategies

- Secure adequate funding for the school.
- Question the need for the same level of entry qualification level for assistant training as for Technician training.
- Ensure all graduates are absorbed, well paid and staff quarters should be made available.

4. Radiographer/X-assistants

Current situation

- There is a deficit of 30 radiographers in MOHS.
- Radiographers are not trained locally.
- X – Assistants are trained on the job.
- There is a deficit of 2 X – assistants

Strategies

- Train at least two (2) radiographers every year.

Pharmacy Group

1. Pharmacists/Pharmacy Technicians

Current situation

- There are 13 pharmacists in post for MOHS.
- MOHS has a deficit of 36 pharmacists plus a 10% allowance of MOHS deficit for mission/private/NGO and upcoming government pharmacy services making a requirement total of 43.
- MOHS has a deficit of 60 pharmacy technicians plus a 10% allowance of MOHS deficit for mission/private/NGO and upcoming government services making a requirement total of 66.
- The pharmacy technician school output is 25. The deficit should be covered within the plan period.
- The training output of pharmacist is 7
- The target for pharmacist will not be achievable during the plan period at the current output level.
- There will be a shortfall of 31 pharmacists.

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Strategies

- Increase the output of pharmacist to 13 per year.
- Ensure early absorption into government service for new graduates.
- Provide good remuneration and staff quarters.

6.3.1 General HR strategies

1. There should be clear cut policies and guidelines on human resource development e.g locally trained personnel should serve the country for a minimum period of 3 years before embarking on any other pursuits.
2. External trainees benefiting from government scholarships must be bonded for a minimum period of 3 years of national service.
3. All health professionals wishing to practice in any district of Sierra Leone must register nationally and locally.
4. MOHS should strive to strengthen supervision at all levels by :-

   a) Providing adequate logistics;

   b) Standardizing supervisory protocols; and

   c) Establishing an effective and efficient computer network in the country.

5. New graduates from training institutions should be promptly absorbed to avoid frustration and consequent brain drain.
6. Proper and adequate career paths to allow automatic promotion and that promotion should be based on merit.
7. MOHS should educate professionals on conditions of service and public service rights.
8. It is also desirable that better salaries should be paid in time.

6.3.2 Prioritization

The staffing standards for MOHS represent staffing target. The targets for the small private, mission and Muslim health facilities are not known. The supply driven projection made earlier on shows that these targets are basically unachievable within the five years of the Human Resources Development Plan. The Medium Term Expenditure Framework (MTEF) takes a very different approach, namely that each ministry will only receive a budget for those people actually in post. The approach is of no value in attempting to evaluate training needs as it provides no indication of the shortfalls of staff numbers which training programmes are attempting to correct.

In attempting to prioritise, a comparison of current employee numbers with the current recommended staffing figures for most categories of trained staff has been made. Using these figures is not an acceptance that they are the 'right' figures, just that these are the only stated targets that are meaningful at present. Furthermore the targets should not be regarded as static because of high population growth and that new facilities are steadily coming on stream and can only require additional resources.

The first criterion used for prioritisation is therefore the percentage shortfall against the staffing standards. In addition, factors such as the need to support the thrust of the National Health Policy Framework towards PHC services, the absolute size of the shortfall and the impact of expanding one group at the expense of another were considered.

Priority A

- State registered nurses
- State certified midwives
- Medical officers
- Internal medicine specialist
- Public health specialist

Priority B

- Medical assistants
- MCH aides

- Community health assistants
- Pharmacist
- Radiographers

Priority C

- Laboratory Technicians
- Pharmacy Technicians
- Environmental health officer

6.4 Implementation of the plan

A concerted process of dissemination will be required. It is necessary to use this opportunity to engage major stakeholders including those outside the health sector itself in supporting the continuous updating of the plan.

This plan provides a broad picture of what needs to done based on currently available information. The needs in the plan should be regularly revised.

6.5 Institutional arrangements

Initially MOHP will take the lead, with technical support provided by the human resources section. The HRMD division will be responsible for overseeing the implementation and regular reviewing of the plan.

6.6 Monitoring and Evaluation of the plan

In the process of developing this plan a reasonable quality database has been established and methods of analysis and the skills to use them are in place.
It will be necessary to try to find ways of capturing data on private sector including NOGs.

The national Human Resource Information System, which draws on data from individual employers, should be strengthened. In addition, some specific surveys will be required to capture information not collected regularly. For example, progress on establishment of human resources planning and management systems.

Annual monitoring will be by output indicators given in the logical framework that will be refined in year one and revised. The monitoring will be carried out by the human resources division of the MOHS. At the end of year 3 a review will be carried out to judge the likelihood of achieving the stated purpose at the end of the plan period.

The indicators at the purpose level are a mixture of those directly related to human resources strategies (e.g increase the number of staff) and proxy indicators related to service provision. The assumption that accompanies health service indicators is that sufficient complementary inputs are also provided (drugs, equipment, etc).

ANNEXES

ANNEX I : Vacancy analysis in MOHS

LAKKA HOSPITAL SPECIALISED FOR TB AND LEPROSY

CADRE	TOTAL REQUIREMENT	No. IN POST	VACANCY	VACANCY RATE
Medical Officer	**2**	**1**	**1**	**-50%**
TB Specialist	**1**	**0**	**1**	**-100%**
Orthopaedic Surgeon	**1**	**0**	**1**	**-100%**
Orthopaedic Clinical Officer	**1**	**0**	**1**	**-100%**
Orthopaedic Technician	**3**	**0**	**3**	**-100%**
SRN	**4**	**0**	**4**	**-100%**
SECHN	**6**	**9**	**+3**	**+50%**
Infectious Disease Nurse	**6**	**0**	**6**	**-100%**
Laboratory Technician	**3**	**0**	**3**	**-100%**
Pharmacy Technician	**3**	**0**	**3**	**-100%**
Radiographer	**1**	**0**	**1**	**-100%**
Radiography Assistant	**2**	**0**	**2**	**-100%**

CONNAUGHT HOSPITAL

CADRE	TOTAL REQUIREMENT	No. IN POST	VACANCY	VACANCY RATE
Physician	**11**	**0**	**11**	**-100%**
Gastroentorologist	**1**	**0**	**1**	**-100%**
Neurologist	**1**	**0**	**1**	**-100%**
Nephrologist	**1**	**0**	**1**	**-100%**
Surgeon	**9**	**5**	**4**	**-44%**
Anaesthetist	**3**	**1**	**2**	**-67%**
ENT Specialist	**1**	**1**	**0**	**-**
Pathologist	**3**	**1**	**2**	**-67%**
Biochemist	**5**	**3**	**2**	**-40%**
Dental Surgeon	**8**	**0**	**8**	**-100%**
Physiotherapist	**2**	**1**	**1**	**-50%**
Assistant Physiotherapist	**1**	**0**	**1**	**-100%**
Cardiologist	**3**	**1**	**2**	**-67%**
Nutritionist	**3**	**1**	**2**	**-67%**
Assistant Nutritionist	**1**	**0**	**1**	**-100%**
Chiropodist	**1**	**1**	**0**	**-**
Radiologist	**4**	**1**	**3**	**-75%**
Radiographer	**7**	**2**	**5**	**-71%**
Dermatologist	**3**	**0**	**3**	**-100%**
Pharmacist	**2**	**0**	**2**	**-100%**
Medical Officer	**29**	**15**	**14**	**-48%**
Registrar	**6**	**0**	**6**	**-100%**
SRN	**170**	**24**	**146**	**86%**
Nurse Anaesthetist	**4**	**2**	**2**	**-50%**
Theatre Nurse	**6**	**0**	**6**	**-100%**
SECHN	**147**	**79**	**68**	**4%**
Laboratory Technician	**21**	**14**	**7**	**-33%**
Laboratory Assistant	**15**	**3**	**12**	**-80%**
Dental Technician	**7**	**0**	**7**	**-100%**
Pharmacy Technician	**10**	**12**	**+2**	**+20%**

CHILDRENS' HOSPITAL

CADRE	TOTAL REQUIREMENT	No. IN POST	VACANCY	VACANCY RATE
Paediatrician	**6**	**3**	**3**	**-50%**
Medical Officer	**6**	**7**	**+1**	**+17%**
Pharmacist	**2**	**0**	**+2**	**100%**
SRN	**22**	**21**	**1**	**-5%**
SECHN	**36**	**38**	**+2**	**+6%**
Pharmacy Technician	**4**	**0**	**4**	**-100%**
Radiologist	**1**	**0**	**1**	**-100%**
Radiographer	**1**	**0**	**1**	**-100%**
Nutritionist	**1**	**1**	**0**	**0**

PCM HOSPITAL

CADRE	TOTAL REQUIREMENT	No. IN POST	VACANCY	VACANCY RATE
Gynaecologist/Obstetrician	**3**	**5**	**+2**	**+67%**
Medical Officer	**9**	**5**	**4**	**-44%**
Pharmacist	**2**	**0**	**+2**	**100%**
Staff Midwives	**9**	**51**	**+42**	**+497%**
SECHN	**30**	**58**	**+28**	**+93%**
Laboratory Technician	**4**	**0**	**4**	**-100%**
Pharmacist	**1**	**1**	**0**	**0**
Pharmacy Technician	**6**	**4**	**2**	**-33%**
Nurse Anaesthetist	**4**	**1**	**3**	**-75%**

DISTRICT HOSPITALS

CADRE	TOTAL REQUIREMENT	No. IN POST	VACANCY	VACANCY RATE
Medical Officer	**60**	**21**	**39**	**-65%**
Pharmacist	**30**	**13**	**17**	**57%**
Staff Midwives	**390**	**58**	**332**	**-85%**
SRN	**380**	**44**	**336**	**86%**
SECHN	**460**	**211**	**249**	**54%**
CHO	**30**	**8**	**22**	**-73%**
Ophthalmic Technician	**15**	**0**	**15**	**-100%**
Ophthalmic Nurse	**30**	**1**	**29**	**-97%**
Physiotherapy Assistant	**15**	**0**	**15**	**-100%**
Dental Technician	**15**	**0**	**15**	**-100%**
Radiographer	**15**	**0**	**15**	**-100%**
Pharmacy Technician	**75**	**24**	**51**	**-68%**
Nurse Anaesthetist	**45**	**5**	**40**	**-89%**
Theatre Nurse	**45**	**0**	**45**	**-100%**

PROVINCIAL HOSPITALS

CADRE	TOTAL REQUIREMENT	No. IN POST	VACANCY	VACANCY RATE
Medical Officer	**54**	**10**	**44**	**-81%**
Physician	**6**	**1**	**5**	**-83%**
Surgeon	**9**	**1**	**8**	**-89%**
ENT Surgeon	**3**	**0**	**3**	**-100%**
Dermatologist	**6**	**0**	**6**	**-100%**
Paediatrician	**3**	**0**	**3**	**-100%**
Gynaecologist/Obstetrician	**3**	**2**	**1**	**-33%**
Pathologist	**3**	**0**	**3**	**-100%**
Laboratory Technician	**15**	**9**	**6**	**-40%**
Radiographer	**9**	**0**	**9**	**-100%**
Pharmacy Technician	**12**	**18**	**+6**	**+50%**
Staff Midwives	**21**	**28**	**+7**	**+33%**
SRN	**303**	**20**	**283**	**93%**
SECHN	**255**	**91**	**164**	**64%**
Ophthalmologist	**3**	**0**	**3**	**-100%**
Ophthalmic Technician	**18**	**0**	**18**	**-100%**
Ophthalmic Nurse	**18**	**0**	**18**	**-100%**
Dental Surgeon	**3**	**2**	**1**	**-33%**
Dental Technician	**12**	**0**	**12**	**-100%**
Nurse Anaesthetist	**15**	**3**	**12**	**-80%**

Annex II

DISTRIBUTION OF (MINOR SUPPORT STAFF) BY CADRE AND BY LEVEL OF CARE

CADRE	TOTAL	CHLD HOSP	CONN HOSP	MENTAL HOSP	LAKKA HOSP	PCM HOSP	CHC	CHP	MCHP	CMS	DISTRICT	PROVINCE	OTHER GOVT H/S
Accounts Clerk	**55**	1	9	2	0	1	0	0	0	1	11	6	
Artist	**5**	0	0	0	0	0	0	0	0	0	0	0	
Caterer	**18**	1	4	1	1	4	0	0	1	0	3	2	
Cleaner	**151**	14	6	2	2	0	11	0	1	1	30	2	
Cloakroom Attendant	**24**	0	2	3	0	6	0	0	0	1	3	7	
Cook	**87**	5	13	6	2	5	0	0	0	0	19	10	
Carpenter	**21**	0	3	0	0	2	0	0	0	1	2	0	
Dental Assistant	**16**	0	0	0	0	0	0	0	0	0	1	0	
Driver	**131**	3	10	0	4	2	0	0	0	0	21	7	
Driver's Mate	**25**	0	3	0	0	0	0	0	0	0	7	0	
Electrician	**11**	0	1	0	0	1	0	0	0	0	0	0	
Filing Clerk	**48**	0	6	7	0	3	0	0	0	0	1	4	
Labourer	**394**	2	22	2	1	6	21	7	9	12	81	20	
Laundress/Laundryman	**41**	5	10	0	2	5	0	0	0	0	19	0	
Mason	**4**	0	1	0	0	0	0	0	0	0	0	0	
Mechanic	**42**	0	0	0	0	0	0	0	0	13	5	0	
Messenger	**50**	3	5	3	0	1	1	0	0	0	3	1	
Mental Attendant	**73**	0	0	73	0	0	0	0	0	0	0	0	
Night Soil Man	**4**	0	0	4	0	0	0	0	0	0	0	0	
Nursing Aide	**628**	35	63	0	0	34	35	10	3	0	220	87	
Painter	**2**	0	1	0	0	0	0	0	0	0	0	0	
Plumber	**5**	0	1	0	0	1	0	0	0	0	0	0	
Porter	**295**	9	23	7	8	17	48	22	8	0	65	37	
Public Health Aide	**127**	1	19	0	0	0	6	1	0	0	6	0	
Projectionist	**1**	0	0	0	0	0	0	0	0	0	0	0	
Records Clerk	**198**	18	21	0	1	16	20	0	5	0	32	16	
Secretary/Typist	**35**	0	0	0	1	0	0	0	0	5	1	0	
Security/Watchman	**381**	10	33	19	6	15	49	6	1	28	75	13	
Steward/Stewardess	**42**	0	14	9	0	12	0	0	0	0	0	0	
Store Clerk	**32**	0	2	0	0	1	0	0	0	23	1	1	
Statistical Clerk	**8**	0	0	0	0	0	0	0	0	0	0	0	
Tailor	**19**	0	12	0	0	0	0	0	0	0	5	1	
Telephonist	**12**	0	0	0	0	0	0	0	0	0	0	2	
Vector Controller	**46**	0	0	0	0	0	0	0	0	0	5	0	
Vector Spotter	**24**	0	0	0	0	0	0	0	0	0	1	0	
Welder	**3**	0	0	0	0	0	0	0	0	0	0	0	
X-Ray Assistant	**7**	2	3	0	0	0	0	0	0	0	1	1	

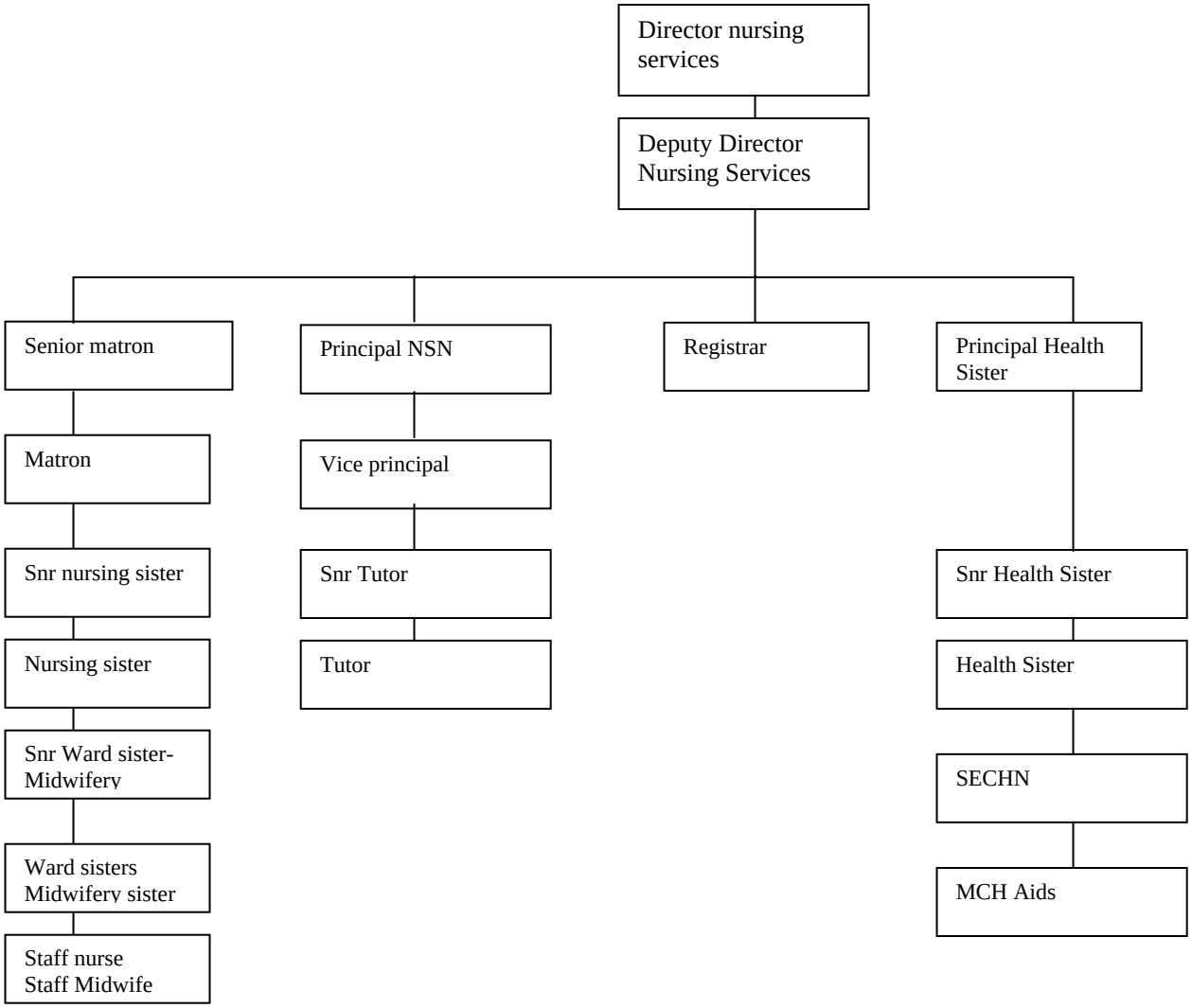
Annex III

DISTRIBUTION OF PRIVATE HEALTH CARE PERSONNEL BY CADRE AND BY REGION

CADRE	TOTAL	EASTERN REGION	NORTHERN REGION	SOUTHERN REGION	WESTERN AREA
CHO	37	6	4	19	8
EHO	3	2	0	0	1
Gynaecologist/Obstetrician	3	1	0	0	2
Laboratory Assistant	5	1	3	1	0
Laboratory Technician	11	3	3	2	3
MCH Aide	30	6	9	9	6
Medical Officer	36	6	1	8	21
Nurse Anaesthetist	4	0	1	0	3
Nursing Aide	144	39	47	45	13
Nutritionist	2	0	2	0	0
Ophthalmic Technician	6	0	6	0	0
Orthopaedist	1	0	0	0	1
Paediatrician	5	1	0	0	4
Pharmacist	72	1	2	13	56
Pharmacy Technician/Druggist	153	3	2	17	131
Physician	4	1	1	1	1
Public Health Specialist	1	1	0	0	0
Radiographer	1	0	1	0	0
Radiologist	1	0	0	0	1
SCM	19	3	0	1	15
SECHN	233	32	21	68	112
Secretary/Typist	1	0	0	0	1
SRN	15	4	4	5	2
Surgeon	2	0	2	0	0
ENT Surgeon	2	0	0	0	2
Vaccinator	8	0	1	5	2

ANNEX IV

Recommended structure of nursing services



ANNEX V

SOME STAFF DETAILS

- **Health Aides** are semi-literate or illiterate individuals selected and trained on the job to assist the Public Health Inspector at the Community level. Most of them are paid by the Community. They advise the people on compound and environmental sanitation.

- **Nurse dispenser and the Leprosy trained nurse**: are almost all male nurses excluded from midwifery training who have taken additional training to work in the PHU as Dispensers or Leprosy Assistants. Dispenser's man the Health Clinics which is some chiefdoms have been upgraded to Community Health Centers.

- **Nursing Aid:** Training is not structured; they learn by working with/and assisting nurses for varying periods. There is no entry qualification. It is believed that they provide significant services in the hospitals, particularly in the District and Rural areas.

- **Endemic Disease Control Unit (EDCU) Workers:** There are members of the PHU staff responsible for epidemic and endemic disease control duties.

- **Medical Entomologist Assistants:** They are trained, mainly to identify vectors and their control, to use insecticides safely and to dissect vectors for evidence of infection. They are trained on the job with no limit on the period training.

- **Vaccinators** are EDCU Assistants (and Nursing Aids) trained to become Vaccinators. They train for 21 days and employed mainly on the EPI program.

- **Vector Controllers** are trained for a short period to supervise in the field; there are mainly illiterate staff who spray the insectides.

- **MCH Aides:** They provide midwifery services. They are stationed in the MCH posts and CHC.

- **Social Mobilization Officers** are either Public Health Inspectors or SECHN, given additional training by Health Officers to design and implement health education programmes at Chiefdom level.

- **Community Motivators** include teachers, social workers, health overseers and others with diverse qualification ranging from upper primary to Form V who are already employed and based in chiefdom. They are trained to:

(a) have communication organization skills with emphasis on immunization and;
(b) take health messages from the Peripheral Health Unit (PHU) to the community and from the community to the PHU.

- **Village Health Workers (VHW) & Traditional Birth Attendants (TBA)**

There are community based health workers, identified for training by the village development or health committee and own their allegiance wholly to the community who have become conscientised and determined to tackle their health problems in the spirit of self-reliance, appropriate technology and community participation. The extent to which this goal is achieved depends on the skill of the health workers (i.e. CHO, CHA AND CHA Aide) to guide and work with the community.

The training of the VHW and TBA should be undertaken in the Chiefdom in which they will work by a team of trainers within the District Health Team.

Medical Personnel

- **Medical Officer**

  Medical Officers are graduates from a recognized medical school registered as Medical Practitioners under the Medical Registration Act. The term applies to general Medical Officer, Specialists Medical Officer and Medical Administration unless these are referred specifically by those designations. Medical Officers may be employed in clinical and community health, usually based in hospitals, and also in Medical Administrative roles and as top level Health Officers, District Medical Officers and Hospital Superintendents.

- **Specialist Medical Officer**

  A medical Officer who holds a post-graduate qualification and is registered as a Medical Specialist under the Medical Registration Act. Medical Specialists are employed as public health specialist and Clinical Medical Specialist and Clinical Science Specialists within the hospital service for instance specialist physician, specialist surgeon, obstetrician and gynecologist, pathologist etc.

- **Medical Administrator**

  The cadre comprised Medical Officers who occupy posts that are primarily administrative. These posts are formal at the higher levels at the tertiary hospitals. A medical administrator, may, though not necessarily, hold a specialist's qualification in a clinical specialization, public health or administration.

- **General Medical Officer**

  This is a Medical Officer who is employed neither as a Medical Specialist nor as a Medical Administrator. They are normally employed as Medical Officers in district hospitals and also in tertiary hospitals.

- **Medical Assistant**

  Medical Assistants graduate from a three-year pre-service course at recognized college of Health Sciences. They are registered with the Medical Council as Medical Assistants. Medical Assistants are trained to undertake both clinical and administrative duties. They will be found at secondary and tertiary levels.

Dental Personnel

- Dental Officer
- Dental Officers are graduates from recognized dental school registered as dental practitioners under the dental registration act. The term is used to cover general and specialist Dental Officers. Dental Officers duties may include both clinical and administrative work.
- Dental Therapist
  A graduate of an approved three-year per-service training course at a College of Health Sciences, specifically dental therapists work in mouth under the supervision of Dental Officers and are based in hospitals.
- Dental Technician
  Registration as a Dental Technician under the Dental Registration Act requires the completion of a three-year course at a recognized training institution. Dental technicians are based in hospitals where their principal role is the production and fitting of dental prostheses.

Pharmacy Personnel

- Pharmacists
  Registered by Pharmacy Board. These are degree holders from COMAHS

- Pharmacy Technicians
  Also registered by the Pharmacy Board. They are trained locally over a two period.

Laboratory Personnel

- Laboratory Technicians
  Candidates undergo a two-year upgrading course locally from COMAHS. The Medical Council is responsible for their registration. They work in hospitals.

Medical Imaging Personnel

- Radiographer

Radiographers are not locally trained in Sierra Leone. The Medical Council is responsible for their registration. They work in hospitals.

Physiotherapy Personnel

- Nutritionist
- Nutrition Assistant

They are not trained in Sierra Leone.

Malaria Control Personnel

- Parasitologist
- Entomologist
- Malaria Control Officer
- Malaria Technician
- Microscopist

They are not trained in Sierra Leone.

Health Inspection Personnel

- Environmental Health Officer
  Candidates qualify locally as Environmental Health Officers through three-year training programme at the School of Hygiene. Their responsibilities are focused on Public Health, Communicable disease surveillance and food hygiene practices. They are also responsible for supervising community Health Assistants.

- Community Health Assistants
  This category will be trained locally through a two-year training programme at the Paramedical school. Their responsibilities combine preventive and promotive health with environmental health, water and sanitation mainly in rural areas. These will be based in PHUs.

  Health Education Personnel
- Health Education Officer
- Assistant Health Education Officer
  Both cadres are not locally trained responsible for preparing material and disseminating health education material to the populace.

Nursing Personnel

- Registered Nurses
  Registration as a nurse under the Nurses Registration Act requires the completion of an approved three-year pre-service training course. Post-basic training may lead to a registerable award in specialized nursing such as midwifery, maternal and child heath and community nursing education. These post basic qualifications are registered under the Nurses Registration Act.
- State Enrolled Community Health Nurses