Health Reform in Africa

Lessons from Sierra Leone

Bruce Siegel
David Peters
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FOREWORD

In recent years, there has been heightened concern about the need for health sector reform in developing countries. Faced with limited resources, nearly all countries are striving to improve the effectiveness, quality, and coverage of health systems. This paper provides a framework for analyzing the critical elements of reform, examining in depth the experience of one country, Sierra Leone. The example of Sierra Leone describes the actual follow up on the ideas proposed in Better Health in Africa. It demonstrates one country's attempts to improve health despite significant constraints, by reforming health care systems to use available resources more productively, and by increasing accountability to households.

The Sierra Leone case study is also an example of a new trend in investment lending, the sector-wide approach. Government is firmly in control of a reform process that is sector wide in scope, and seeks to improve health systems through use of common planning and implementation arrangements with other partners in the health sector.

We hope this study will be useful to policymakers, staff in donor organizations, and others working in the health sector to identify issues and implement strategies for health reform.

David de Ferranti
Director
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ABSTRACT

Health reform is a widely used term across the world. However, little work has been done to identify its processes, dynamics, and key factors for success, especially in the developing world. This paper describes the elements of health reform in one African nation, Sierra Leone, where progress is being made despite poor economic and security conditions. Within the framework of a National Health Action Plan, Sierra Leone is seeking to overhaul its health system and to focus it on populations with the greatest need. This paper systematically discusses the context, content and processes of health reform in Sierra Leone. In reviewing actions taken and proposed in reforming a package of services, the organization of service provision, and the financing of the health sector, the role of key stakeholders are highlighted. From this case study, six critical success factors are identified: (1) strong leadership; (2) broadening the arena of stakeholders; (3) managing the donors; (4) moving toward a task culture; (5) clear prioritization; and (6) the celebration of success. The paper concludes with an assessment of future prospects for health reform in Sierra Leone.
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I. INTRODUCTION

Poor health continues to afflict large parts of the developing world. High rates of preventable illness and low life expectancy affect the lives of hundreds of millions. Much of this suffering is concentrated in Africa. There, years of economic stagnation, coupled with political instability, have created an environment in which health and health care have greatly deteriorated. Despite these conditions, there is reason for optimism. A recent landmark World Bank publication, *Better Health in Africa*¹ noted that significant improvements in health have been achieved in several low-income African nations despite very tight financial constraints. It was also found that the cost of providing an “essential” package of services to every individual would cost no more than the current health expenditure of many of these nations. However, gross inefficiencies and inequities in the design and execution of current programs now lead to poor outcomes in many countries.

The idea that health sector reform should address issues of efficiency, equity, and effectiveness has a nearly global appeal. Health reforms are underway in many countries at all levels of income.² Although much has been written about health reform in recent years, particularly in higher income countries, there is relatively little systematic analysis of how health reforms are developed and implemented, almost none of it based on African experience. It has become easy to write and speak of “reform” without going into detail about what exactly is being reformed. Even the most straightforward funding reductions to certain health and social programs have been termed “reform.” But implicit in the word “reform” are concepts of improvement as well as change. What is actually being reformed in a reform initiative? What are the essential political and policy elements needed for reform to succeed? What is the role of various stakeholders in these processes? This paper will seek to answer these questions, using
the experience of Sierra Leone as a case study. This country was selected because its reform effort is well documented and appears to be bearing its first successes. Sierra Leone is a low-income nation which appears to be making great strides in health against daunting odds, and we are in a unique position to study just how and why this is happening.

In this paper, Walt and Gilson’s framework for health policy analysis is used as a basis for analyzing health reforms in Sierra Leone (see Figure 1). According to this framework, the execution of sector reform is dependent on the context in which health reform is introduced and executed, the content of the reform itself (the design of what is actually reformed), and process by which reforms are developed, implemented, and evaluated, and the interaction of stakeholders who are affected by, and influence the context, content, and process of sector reform. None of the elements of reform should be viewed in isolation, they are inter-related in many complex ways which change over time. Although each aspect of the framework will be examined in the case of Sierra Leone, the paper will focus on areas that are most often overlooked, the key processes and central role of various stakeholders in reform.

**FIGURE 1**

Framework for Analysis of Health Sector Reform

CONTEXT

STAKEHOLDERS

CONTENT

PROCESS

II. THE CONTEXT

Sierra Leone is a West African nation with a population of approximately 4.5 million in an area of 72,000 sq. km. Despite substantial mineral and agricultural resources, it is classified as a low-income country, with an estimated per capita GDP of $150 in 1993. Health indicators are extremely poor, with an estimated life expectancy of 39 years in 1993. Eighty-nine percent of women were estimated to be illiterate in 1993. Infant mortality in 1993 was 164 per 1,000 live births. Sierra Leone is one of the world’s poorest and least healthy countries.

During the 1980s, Sierra Leone suffered a severe economic decline. Exports of diamonds, gold, coffee and cocoa dropped. Government revenues fell dramatically, and with a lack of fiscal control, economic growth came to a standstill, and inflation soared to 170 percent in 1986-87. After 1989, the government embarked on a structural adjustment program to create an environment for economic growth and reduction of poverty, though it did not immediately restore investment in the health and education sectors.

The recent political history has added to the instability of the economic environment. After independence in 1961, Sierra Leone was ruled by an increasingly corrupt one-party civilian government. The influx of about 200,000 Liberian refugees in 1990 put increasing pressure on the existing government. Sierra Leone’s participation in the ECOMOG peacekeeping initiative in Liberia was followed by an invasion of Liberian rebels in 1991 and domestic insurgency. In April 1992, the military seized power and formed the National Provisional Ruling Council (NPRC) government, with hopes of restoring peace and prosperity. Initially popular, the regime built on the structural adjustment program of its predecessor, but with greater commitment to health and education. Although successful in achieving a level of economic stability (by 1993-
94, GDP was growing at 4 percent per year, and annual inflation was down to 15 percent), the insurgency continued to disrupt life, and there was increasing pressure within the country and externally to return to civilian rule. In January, 1996, leadership of the NPRC government changed, though little change in government policy emerged. National elections were held in March, 1996, and a new civilian government came to power. Despite numerous peace overtures and attempts at mediation by the NPRC, the rebels continued their activities at varying levels of intensity until the final transition to civilian rule. At the time of this paper it estimated that up to 20 percent of the population has been displaced by rebel activity. While peace talks between the warring factions are now underway, the social and economic impact of the war have clearly been enormous.

The nation's health system (Box 1) was placed under enormous stress during the last decade. The system was chronically under-funded and neglected despite the enormous health problems of the country. As government revenues declined, health expenditures were particularly hard hit. Per capita health expenditures declined by over 85 percent between 1980 and 1991. Publicly provided services came to a virtual stand-still. By 1990, government was spending 0.4 percent of GDP on health care, less than 3 percent of total government spending, or less than $1 dollar per capita. There was little management of the sector during this time. Aside from a few donor-funded projects, during the 1980s, no health plans were developed, no attempt was made to reconcile public expenditures on health, and there was little private money available for health. As a result, scarce resources were not well allocated, staff were underpaid, shortages of drugs and medical supplies were rampant, facilities were not maintained, and services were of poor quality. There was little community involvement or accountability in health services, and a parallel private health care system developed within the public health infrastructure.
Sierra Leone's health care is provided by over 500 government health facilities, as well as 35 hospitals and 84 clinics operated by missions and the private sector. The government system includes 27 hospitals, and about 400 'peripheral health units' including smaller Community Health Posts in villages and larger Community Health Centers in towns. Data from the Department of Health (DOH) and WHO reveal that much of the system is in disarray, with many facilities providing inadequate or virtually no service. Joint planning between facilities, and between preventive and curative services, has been nonexistent. Facilities have few resources and budgetary authority, and have had little ability to make any significant independent decisions.


By 1992, the setting was right for health reforms. There was a new government in power, the economy was stabilizing, there widespread recognition that the health sector had collapsed, and donors were willing to return to invest in health. Although the intensifying social upheaval placed more demands on the health sector, leaders in the Department of Health (DOH) were determined to use take the opportunity to carry out an ambitious reform agenda as well as attempt to meet the emergency needs of its injured and displaced persons.

III. THE CONTENT

In discussing the content of health reform in Sierra Leone, description of the processes involved is unavoidable, as the two were closely inter-related. We will thus discuss the policy goals along with the steps taken to arrive at them. The Sierra Leone health reform was intended to be a comprehensive approach to health services, serving to meet multiple, sometimes conflicting goals and objectives.

Although the foundations for increased social investment began with the structural adjustment program, the earliest concrete steps were laid out in a very brief Health Policy and Development Plan in mid-1992, authored by the Secretary of State for Health, which followed
his initial tour of health facilities in the country after taking office. This document called for a plan, “To meet the general health needs of the nation through environmental sanitation, through primary healthy care, strengthening of secondary and tertiary services, improvement in manpower development and utilization at all levels.” It also placed great emphasis on intersectoral cooperation and decentralization.

This was followed by a national Health Stakeholder’s Seminar in September 1992 which helped to create a National Health Policy, released in June 1993. This document built on the previous policy of sector-wide development, and emphasized the need to develop key preventive services. At this time, a number of health sector meetings were convened in Sierra Leone with the assistance of The World Health Organization (WHO). The National Health Policy was then used as the basis for an October 1993 national workshop to create a National Health Action Plan (NHAP). At this time, an attempt was made to review all former government and donor policy documents and statements of goals to form an operational framework for action. The NHAP identifies key objectives, indicators and strategies, and describes a 5-year program of health development, priced at $270 million, covering both recurrent and development expenditures.

The next step was to move from a somewhat ideal, needs-based sector plan, to a more resource-based and flexible plan. Further priority-setting activities, which are described in a later section of this report, focused the plan of five areas: maternal and child health, communicable diseases, nutrition, sanitation, and health education. A core program was developed using these priorities, and estimated to cost less than $150 million. The plan was officially launched by the Chairman of the NPRC, in February 1994 (see Box 2).

The content of the Sierra Leone health reforms has dealt with each of main domains for action in the health sector, and the relationships between them. As described by Berman, these
domains are: (1) The Package of Services; (2) The Organization of Service Provision; and (3) Financing of Health Care (a fourth domain, Use and Demand Factors is addressed below in the Section on Stakeholder Involvement).

**BOX 2. THE NATIONAL HEALTH ACTION PLAN**

Sierra Leone's National Health Action Plan was guided by an ideal vision of a health system for the year 2000. It was designed around 12 broad health objectives. To achieve these objectives, it proposed the integration of many "vertical" programs, increased funding, decentralization of management, donor coordination, community participation, better training, and a redistribution of health facilities

**NHAP Objectives:**

1. Improved child health. 8. Improved living conditions.
2. Improved maternal health. 9. Improved food hygiene.
3. Reduced mental illness 10. Improved knowledge.
4. Reduced injury and handicaps. 11. Reduced prevalence and incidence of common ailments.
6. Reduced drug abuse. 7. Reduced incidence and prevalence of communicable disease.

The basic building block of the new system is to be revitalized Village Health Posts serving 5,000 people. A District Health Management Team would oversee these posts and larger centers. The provincial health management structure would be abolished. District Boards were to be created eventually. The NHAP was costed at $270 million over 5 years.

With the realization that this amount of resources would not be forthcoming, the DOH engaged in several priority-setting exercises to define a "core" program. This program is focused on five programmatic areas:

1. Improvement of maternal and child health. 4. Improvements in sanitation and water.
2. Prevention and control of communicable diseases 5. Health information, education and
3. Nutrition

The five-year cost of this program has been estimated at $148 million. Current levels of government and donor expenditures should provide $86 million. The DOH expects to obtain another $26 million through increased government and household expenditures, leaving a gap of $36 million to be financed through increased donor commitments.

The Package of Services

Defining a package of health services to be provided is most often identified with a rational process of setting priorities. The *1993 World Development Report: Investing in Health* (WDR) placed great emphasis on this, noting that the redirection of government spending to cost-effective programs would benefit the poor.\(^{11}\) The 1993 WDR and later, *Better Health in Africa*, noted that absolute spending was not the sole issue underlying poor health outcomes in the developing world. A poorly defined set of priorities has also contributed greatly to these problems. The concept of disability-adjusted life years (DALY) was promoted in the 1993 WDR as a method for determining which health problems need to be addressed first. Other similar measures, such as years of potential life lost (YPLL) and quality-adjusted life years (QALY) have also been used to these ends.

The case of Sierra Leone demonstrates that setting priorities on a package of services is a complex exercise, and not simply based on a rational criteria and theoretical cost-effectiveness. In the earlier parts of its process, the DOH attempted with mixed success to set national health priorities. Perhaps due to internal political considerations, notably the interests of medical practitioners, equal or greater weighting seemed to be given to the creation of new tertiary care facilities in the capital, relative to funding of an essential package of basic services. Early iterations of the NHAP allocated only 16 percent of new expenditures over 5 years to primary care, a total of $30.2 million. Meanwhile, new capital expenditures for tertiary care facilities were projected at $41.7 million. Sierra Leone seemed well on its way to creating a new tertiary care teaching hospital which would have consumed the bulk of its health expenditures for years to come, estimated at two-thirds of the DOH's current operating budget. Confusion between health problems and strategies was present. Little attention was paid to the relative loss of
disability-adjusted life years. The acceptability, efficacy, feasibility, and effect on equity of various strategies was not analyzed. Addressing the identified priorities would cost far more than could be afforded. And perhaps most important, there had been no public input in creating a list of priorities which would be a guide for better health for the citizenry over the next five to ten years.

In later months, many of these issues were confronted in several ways. At a series of meetings in Freetown in early 1994, key DOH policy-makers and managers, public and private health professionals, community development groups, and donor representatives held discussions and structured “brainstorming” exercises. All were asked “what is the most important problem affecting the health of the people of Sierra Leone?” From this, ten issues were highlighted, including categorical ones like sanitation to more “cross-cutting” problems like the over-centralization of the bureaucracy. These leaders were also asked to anonymously rank the programs and activities of the NHAP. Those rankings were then modified based on the cost-effectiveness, acceptability, feasibility and equity of the relevant strategies, to generate a more final list of health priorities. During this process, several site visits were made to three provincial cities to conduct “town meetings” and focus groups involving over 100 male and female chiefs. Later, in 1994, a beneficiary assessment was conducted which used other qualitative methods to elicit opinions and perceptions around health priorities in three rural and urban sites.12

Through several intensive processes, including these prioritization exercises, the DOH has since been able to re-focus its plans on primary and preventive services. Plans for a new tertiary hospital have been deferred pending further study, while efforts to improve medical education should be reinforced in the coming years.
Organization of Service Provision

The reorganization of services in Sierra Leone focused on four main areas: (1) rationalizing the public sector facilities around delivery of a basic package of care; (2) developing human resources to manage and deliver health services in a more rational manner; (3) reforming the management of the DOH; and (4) developing partnerships. The DOH itself led the way by holding numerous technical meetings, and using consultancies to facilitate the reorganization.

Consistent with its stated priorities, the DOH now hopes to begin strengthening and redirecting its delivery system with a strong emphasis on primary care delivered as part of a package of essential health services. The "peripheral health units" (PHU's) are to be the linchpin of this effort. Under the direction of the NHAP, Village Health Posts and larger health centers will be the main focus of this system. The basic package of clinical and public health services to be provided at the village health posts, health clinics, and district hospitals were established, along with standardized equipment and drugs lists needed to provide the services. They will be supervised by semi-autonomous district management teams, while the next layer, the provincial management, is to be abolished. Operational and financial management will be devolved to the district level, and hospitals and districts are to have their own community boards. The final decision on which functions are to be delegated to the districts or facilities is evolving, as the process of decentralization is planned to occur over several years, beginning with one district in 1996.

Transforming the human resources to support the new package of services required over a year of planning, largely because of the plethora of cadres and numerous training bodies and professional group interests. Technical standards were openly discussed and debated, resulting finally in a plan that was agreed by all concerned (see Box 3). The manpower program
highlighted new training of technical staff, and a new focus on management education and training, both at central and district levels. The changes on the functions and training of staff was facilitated by the parallel changes in the bureaucracy, which was partly designed to improve the incentives and working conditions of health staff in the public sector, while reducing the large numbers of non-service staff.

<table>
<thead>
<tr>
<th>BOX 3. THE HUMAN RESOURCES DEVELOPMENT PLAN</th>
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<td>Sierra Leone’s personnel needs are being addressed through a Human Resources Development Plan (HRDP). It includes two specialized training programs to produce more staff for community health centers, village posts, and hospitals. Under this scheme, newly trained workers would be “polyvalent” - they would have the skills to address a broad array of health and sanitation issues. A variety of current staff would also be “retooled” with similar broad skills. Nine current specialized staff categories (including “vaccinators” and “public health inspectors”) will be abolished.</td>
</tr>
<tr>
<td>By the year 2000, Sierra Leone intends to meet a need of 37 more physicians, 590 nurses, 909 community health aids, and hundreds of other personnel. Most would be trained in Sierra Leone, although some specialized training will be obtained overseas.</td>
</tr>
<tr>
<td>An integral part of the HRDP is a management development program. This program is to support the activities of the NHAP and to be consonant with the broader training being given other workers. A self-assessment given to DOH managers revealed specific weaknesses in certain areas, including performance-based management and handling external relations. A training program lasting 40-55 days for senior and middle managers is now being implemented. It focuses on basic management skills, performances, customer service, work planning, coaching skills, and computer literacy.</td>
</tr>
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Most health reform undertakings involve a change in the administrative hierarchy or apparatus. Recently in West Africa, this has often taken the form of decentralization of the ministry of health or equivalent organizations. Sierra Leone has been no exception. But some other features of Sierra Leone’s bureaucratic reforms are also worth noting.

A March 1994 assessment of the DOH included a survey of its leadership cadre. Over 60 percent of the respondents characterized the DOH as operating as a “power” culture. Such a culture is characterized by a central power source, few formal rules, and a decision-making
process based on influence and individuals rather than logic and group processes. While this is hardly surprising, the DOH has taken steps (to some degree unintentionally) that begin to transform this culture into a more formalized, decentralized, task-oriented organization.

Much of this work has involved the use of teams to solve problems. The National Health Policy, the National Health Action Plan, the various priority-setting and now implementation exercises are all being accomplished using teams of individuals from within and without the DOH. These teams are assigned a very specific goal within given expectations and time frames. For DOH staff, this has meant a very new way of doing business. It has also meant a significant growth in their confidence and morale. The DOH initiated these reforms and is now working (apparently successfully) to implement them. Few things are more invigorating to an organization with low morale.

Other traditional steps to streamline and pare down the bureaucracy are also being taken. The DOH’s staff has been reduced dramatically, especially with cuts to the number of day workers. The proportion of DOH’s budget allocated for personnel costs has dropped from more than 63 percent in fiscal year 1992-93 to 30 percent in fiscal year 1994-95. This has been driven by a net reduction of over 5,000 personnel in the same period. Figure 2 shows the decrease in staffing levels over time.

This reduction in staff has been part of Sierra Leone’s national effort supported by the International Monetary Fund and the Bank. The shrinkage has been accompanied with less trouble than might be imagined. Many of the eliminated employees were non-existent “ghost workers.” Others were workers over the mandatory retirement age of 55.
FIGURE 2


Source: Government of Sierra Leone—Accountant General’s Office.

The antiquated civil service and compensation structures of the DOH are also being addressed in the context of government-wide reforms in Sierra Leone. The DOH currently has little control over how its employees are paid. Few incentives or awards exist for excellence. The pay for professional staff has been estimated to be equivalent to 25-50 percent of a living wage. For non-managerial staff, the situation is far worse. As a result, employees at all levels are forced to supplement their pay through extramural activities or through unofficial patient fees. A survey by the government found that salaries were, on average, seven times higher in the private sector.

The Government of Sierra Leone (GOSL) has begun to simplify the civil service grading system and plans to introduce “market premiums” for certain titles. It has also indicated that it will allow the DOH authority to decide manpower budgets, determine recruitment and personnel practices, and have discretion over an individual’s pay within established salary structures. However, final action on these items is yet to occur.
The final area where organization of the provision of services has changed is in the development of partnerships. Greater recognition of the role of non-governmental organizations (NGOs) was explicitly made by including representatives in the policy and planning exercises, and by the establishment of an NGO liaison office in the Department. Similarly, private medical practitioners were involved through their professional association in the development of the National Health Policy and the NHAP. The government is promoting the provision of services through the NGOs and for-profits providers, and has allowed government health workers to conduct private practice. However, further definition of roles and regulations is planned during the next five years.

**Financing of Health Care**

At the heart of any reform initiative is change in the financing of health care. In Sierra Leone, this has involved increasing the overall allocation of resources to the sector, improving its allocation, and introducing new mechanisms of financing and provider payment. By May, 1994, the GOSL committed itself to raise social and health service expenditures 5 percent per year as part of its Structural Adjustment Program, while the international donor community has committed itself to increase funding to meet the unmet needs of the core plan. Numerous institutional and population-based assessments have been made since early 1994 as the DOH implements the plan and donors prepare to add their resources.

Already, government financial health expenditures have increased dramatically over the past several years (see Figure 3). The proportion of Sierra Leone's national budget devoted to health has more than doubled in the past five years (2 percent in 1990 to 5 percent in 1994), and as a proportion of GDP, government health expenditure steadily increased from 0.4 percent in
1990 to 1.0 percent in 1994. In per capita terms, the government spent $1.6 in 1994. Over the next five years, government health expenditures are planned to increase to over 6 percent of government expenditures. Donors have been estimated to be contributing about $1.5 per capita in recent years in the health sector (though this is clearly an underestimate). Over the next five years, the committed amounts are closer to $3 per capita. Whereas Sierra Leone would continue to be considered a "low" health expenditure country relative to other African nations, these trends have nevertheless been dramatic increases.

FIGURE 3

Other changes in government are facilitating the changes in financing. For the first time ever, the DOH completed its own projected budget in March 1995. This was the result of the planned devolution of much line-item budget authority from the Department of Finance (DOF) to other governmental departments. Personnel authority and other control is also to be devolved to DOH. The Department is, for the first time, gaining authority and responsibility over its own activities.
The changes in allocation to improve expenditure on the basic package of services is reflected in the budget and expenditure patterns at the DOH. The 1995 DOH expenditures reflects the new priorities on prevention and primary care (see Table 1). For 1996, the total sector budget (including DOH and donor contributions) allocated 44 percent of the budget to primary services and district management (a conservative estimate since drugs and training budgets were not allocated across levels of care), while holding 18 percent of the budget for central hospitals. As well as a shift toward primary care, there has been an remarkable shift in the composition of DOH recurrent expenditures. In 1992, more than 63 percent of recurrent expenditures were made on personnel (see Figure 4). From 1993-96, the figure has remained around 30 percent, in an effort to recover from the chronic under-funding of supplies and maintenance. Furthermore, since 1993, over 95 percent of the DOH budget has been spent, whereas previously actual expenditures were not known.

**TABLE 1. DEPARTMENT OF HEALTH FISCAL 1995 EXPENDITURES**

<table>
<thead>
<tr>
<th></th>
<th>Funds (000's US$)</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary &amp; Preventive Services</td>
<td>7,024</td>
<td>31.0</td>
</tr>
<tr>
<td>Hospital &amp; Laboratory</td>
<td>5,117</td>
<td>11.4</td>
</tr>
<tr>
<td>Drugs and Medical Supplies</td>
<td>3,897</td>
<td>17.2</td>
</tr>
<tr>
<td>Support Services*</td>
<td>5,822</td>
<td>25.7</td>
</tr>
<tr>
<td>Other(^1)</td>
<td>797</td>
<td>3.6</td>
</tr>
</tbody>
</table>

\(^*\) includes maintenance, administrative, and planning costs at district and central levels  
\(^1\) primarily emergency assistance

Source: Sierra Leone Department of Health, March 1995.
Reform of financing is intended to reach beyond government spending, and to cover the entire health sector. User fees are being implemented in a more transparent manner to improve cost-recovery mechanisms. Household fees are expected to contribute $4.6 million to the $62 million in new financing expected for the core program. In the past, private expenditures, though largely unknown, were estimated at $3.7 per capita in 1990. Numerous recommendations for the government to expand private finance and ownership of Sierra Leone’s health system have also been made. These recommendations seek to better define the appropriate roles of the public and private sectors in Sierra Leone’s health system.

As a result, the GOSL has facilitated two projects which will increase private health care finance, while freeing public investment for primary care. In the first project, the GOSL is assisting a local foundation in the construction of the new 56-bed, $2 million T. Choithram Hospital near Freetown. The government is assisting by clearing regulatory and other hurdles that would otherwise impede the project. In the second example, a recently rehabilitated portion of Connaught Hospital, termed the “Annexe,” has recently been opened. It is staffed by local physicians, intended for a Freetown clientele and is financed by privately collected fees.
The DOH is now considering proposals for setting fixed physician fees to prevent overcharging. It is expected that it will be some time before any final decisions are made in this area due to the potential volatility of this issue.

IV. THE PROCESS

The processes described above were primarily used to establish priorities and develop consensus for the health reforms. Box 4 details those activities that were used to set priorities. They were the first known instances of the DOH (with some external consulting assistance) formally surveying “at-large” populations for their input and opinions. This had the result of greatly raising expectations around the progress of health reform nationally. The stakeholder meetings in Freetown around priority-setting raised expectations within the GOSL and DOH bureaucracies, and also seemed to help empower administrators to become comfortable with group problem-solving and tasks. All of this has important implications for other elements of reform.
BOX 4. SETTING PRIORITIES IN SIERRA LEONE

The Sierra Leone reform effort has used a number of techniques to determine what needs should be addressed within the rubric of the NHAP. In November 1993, the plan itself was drafted using the participative ZOPP methodology developed by the German technical assistance agency GTZ. This resulted in the original 12 objectives of the NHAP. With the need to further focus the plan, in early 1994 the DOH and World Bank conducted a series of exercises designed to further refine the original objectives. These included:

- Interviews with key leaders in several government agencies including the DOH and the Sierra Leone Women's Development Movement.
- Six "town meetings" with male and female chiefs in these provinces.
- A structured brainstorming session with several dozen health professionals, DOH and DOF staff, and donor representatives.
- A survey on health needs administered to the same professionals and staff. Respondents were asked to take health need, cost-effectiveness, operational feasibility, cultural acceptability and equity into account. Data on cost-effectiveness from the 1993 World Development Report was presented to respondents.

Based on this survey, 8 major programs and 45 related activities were explicitly ranked. The five most highly ranked programs have since been adopted as the DOH's "core program." As a result of these exercises, the construction of a new tertiary care hospital was also deferred.

In 1994-1995, a detailed beneficiary assessment was also conducted in three sites. Several data collection procedures were used. The poorest households were a major focus of the study. This assessment found that many health problems were more closely linked to poverty and poor communication by local people.

While all of these exercises have helped provide data to planners, they have also built an exceptional level of support for reform among Sierra Leone's people.


V. STAKEHOLDER INVOLVEMENT

Regardless of the local level of development, stakeholders are perhaps the most important arbiters of whether reform proceeds. Their definition can also be important. In Sierra Leone, a number of stakeholders were identified by the DOH. But others have been ignored with potentially serious consequences. For Sierra Leone, the stakeholders or constituencies who have played key roles include: (1) Community Representatives; (2) the DOH; (3) The Department of Finance; (4) Health Professionals; (5) The Donor Community; and (6) the Academic Community.
Community Representatives

The public prioritization exercises signaled a greater appreciation of the role of the community. This recognition may occur in formal settings, through the creation of standing health planning councils or committees at local levels. Or, it may be informal, through ad-hoc meetings and techniques as has been the case in Sierra Leone to date. More formal processes may insure these activities continue, which is critical as they are rarely the favorite activity of the bureaucracy. But formal processes generally run a greater risk of “capture” by elites or well-organized interests.

Unfortunately, many Sub-Saharan health initiatives seem to be planned with little attention to the need to both talk to and listen to those who are supposed to benefit from change. Sierra Leone made its first small, but significant steps in this direction. The more recent parts of the reform process seem to have maintained some of this momentum. The framework for carrying the national initiative to the district level notes the importance of “community education.” But there is less evidence that listening activities are being maintained. This is worrisome, especially as many consumers in various site meetings expressed their ongoing frustration at their lack of influence over the management of local health projects.

While it is easy to treat consumers of health services as one undifferentiated group, the fact is that Sierra Leone’s consumers fall into different categories. Over two-thirds of the population lived in absolute poverty by 1989-1990. But Sierra Leone also has an active mining sector, and has had an expanding “parallel” economy in trade and foreign exchange. Like most nations, there is an affluent elite. A small middle class also exists, which seems to be composed, in large part, by white collar government workers.
With this backdrop, the role of consumers becomes more complex. The priority-setting exercises in early 1994 dealt largely with chiefs outside of Freetown. These were hardly the most impoverished. These groups voiced a great demand for basic health services and for greater say in the management of these services. While women seemed to demand more preventive services than the men, all were excited by the prospect of any new investment in health in their districts. These meetings, in many ways, raised expectations about the NHAP and mobilized support for it.

The Beneficiary Assessment included more contact with the very poorest Sierra Leoneans in three communities. These communities wanted more health services, though they saw the root causes of their ill health as poverty and an inferior food supply. They too decried the lack of dialogue with government health officials and the lack of public accountability in the health system.

As one ascends the income scale, the stakeholders’ interests become somewhat different. For the upper groups in Sierra Leone, the current system, however flawed, includes some benefits. It provides a health care subsidy in the form of urban hospitals. It even flies certain people out of the country for treatment abroad. It also provides a source of private income, especially for those practitioners who collect private fees. The most notable feature here has been the neutralization of potential opposition from these elites, not the mobilization of support among poorer, rural groups. The decision to defer construction of a new teaching hospital was the denial of what would have been a substantial health care and income subsidy to many groups. We can only ascribe this to the strong leadership of the reform effort, and to their having a clear vision of what the country needs, and does not need.
The Department of Health

During the 1980s, the DOH saw its resources, ability to deliver services, and prestige erode. The recent health reform effort may reverse this trend. While, in many instances, it has been forced to "swim against the tide," the DOH has been fortunate to have a leadership cadre with vision and political will. Foremost among these has been the Secretary of State for Health. Energetic and focused, he has continually pushed forward despite difficult odds. Unlike other agency heads, he has stayed personally involved in the effort without engaging in micro-management. Around him he has also begun to build a team of like-minded individuals. At least the higher echelons of the DOH are now staffed by National Health Action Plan advocates. The movement towards a "task culture" has also helped to revive the DOH.

The DOH should not, however, be viewed as a monolithic organization. It is a far-flung national entity, with its own internal divisions. The interests of a district or community center manager may be very different than those of a central administrator in Freetown. One of the successes so far of the DOH team has been in keeping these various groups aligned.

Two recent events have signaled the prominence that DOH and its Secretary have gained: The first is the granting of the Heroes Day Award to the DOH, recognizing it essentially as the pre-eminent GOSL department in 1994. This was a major affirmation and celebration of its efforts. The second was the ascent of the Secretary of State for the Department of Health to the position of Chief Secretary of State in March 1995, and to Vice Chairman in January, 1996. This is a good indication of the political skills that have made this reform effort work to date.
The Department of Finance and GOSL

For purposes of this discussion, we will consider these as one. Like most administrative departments, the DOF has been somewhat reluctant to accede to all the demands placed on it by the DOH. Yet, these demands have been entirely consonant with the overall thrust of reform across the GOSL. Decentralization, delegation of budget and personnel authority, transparency, civil service reform, creation of meaningful financial incentives; all these elements have been sought by the DOH and fit into the GOSL agenda. So it has been difficult for the GOSL or DOF to be too intractable. The DOF has also had to consent to the growth of the DOH budget over time.

The chief of any cabinet-level agency must be adept at “managing” the government’s chief administrative and budget officers (be that the DOF or the Department of Establishments, or the Office of Management and Budget). The DOH has succeeded in this task using three methods. First, its demands for budget and personnel authority have fitted nicely with the overall thrust of reform in the GOSL, which emphasizes decentralization. Second, the DOH has created a national constituency for its efforts, especially through its public exercises. Third, the DOH has enlisted the help of international donors in making the case for health to the rest of the GOSL. All of this has helped the DOH to create an enabling environment for its reform effort.

To date, most of the DOF’s and GOSL’s commitments to the DOH are yet to be realized. For instance, full line-item budget authority and personnel discretion are not yet effective, although significant steps have been taken in that direction. The proof of the commitments will be found over the coming years, if they can continue to achieve the budgetary targets for health, and whether full delegation of budgetary authority occurs.
Health Professionals

This is a stakeholder group with perhaps the most complex motivations. While good statistics are lacking, it appears that most physicians and other nontraditional practitioners are employed by the DOH at wages of under $100 per month. However, most of their income is derived from other unofficial sources, especially from sanctioned and unsanctioned private charges. At Connaught Hospital in Freetown, for instance, it was estimated that a surgeon would collect Le25,000 for an appendectomy in early 1995, a very significant sum of money in Sierra Leone (the equivalent of about 3 months average income). Thus, while most physicians are DOH workers, it is hard to see them as being completely aligned with the DOH. Sierra Leone’s physicians inhabit a quasi-official professional and economic space. To the extent that health reform allows practitioners to maintain income by supplementing very meager salaries, it may be welcomed by these stakeholders. To date, the reform agenda has aimed to increase official compensation while allowing unofficial income as well. If that direction were to change, support might accordingly drop.

Health care providers may also see health reform as an opportunity to look at new delivery and finance systems. Specifically, they may see this as a prelude to privatization of parts of the delivery system, or of the creation of private insurance schemes as some have advocated for Sierra Leone. This could clearly open up new avenues of innovation and entrepreneurship. The construction of T. Choithram Hospital and creation of the Annexe at Connaught Hospital are first steps in this direction.

In reality, the DOH has spent little effort on either listening to, or developing a health providers constituency. This may be a future worthwhile endeavor. A vocal expert community
could be a very powerful partner for the DOH in future debates. If not managed, that community could become the Department’s most effective opponent.

**The Donor Community**

Nowhere has the reform leadership been more successful than in its management of these key stakeholders. Donors are clearly key to the success of this effort. Their technical assistance, political support and, of course, finances are needed. They can also, unfortunately, become some of the greater obstacles if they set the agenda as well.

Sierra Leone has faced just this problem. At one point, the DOH estimated it had 47 different units dedicated to implementing various donor-funded projects. Much of this work is coordinated now through a new Donor Relations Secretariat. This reflects the DOH’s desire to be sensitive to donor priorities, but to make those priorities fit within a larger framework.¹⁸

Most important has been the DOH’s creation of a National Health Action Plan and a fairly firm insistence that all health sector activities and investments be planned within that framework. By initiating development of its own reform agenda, the DOH has largely preempted any externally-imposed agenda. It is an active creator, not a passive recipient. In many developing countries, the government is not even aware of any of the health initiatives underway; in Sierra Leone, the government has created most of them. The DOH has used donor assistance as needed, but has been able to continue its ownership of the process. In turn, it has expanded its own institutional capacities while making difficult decisions based on hard realities.

The DOH has also enlisted the support of the donors in putting health on the GOSL’s agenda. By initiating a reform effort and by creating its own channels of communications to the
donor community, the DOH was able to start a dialogue which forced the attention of the GOSL and the DOF.

The Academic Community

Local academic institutions can often serve as invaluable catalysts or laboratories for health reform. They can also help increase accountability by publicizing data and benchmarks that might not be otherwise available. Clearly, they also have a role in training the next generation of health workers.

To date, there has been little progress on this front. While a College of Medicine and Allied Health Services (COMAHS) was founded in 1988, the future role envisioned for it is essentially as a "producer" of doctors, dentists, pharmacists and radiographers. By so narrowly defining COMAHS' role, a significant opportunity is being lost. The national academic infrastructure could be much more closely tied to identifying and solving problems faced by Sierra Leone. A community-based academic program can have a very major effect on the creation and implementation of a reform agenda. It can develop new models of delivery, tailor them to local needs, and then actually create and refine them. Alternatively, it can work on larger scale issues. A greater role on the part of academia in creating the National Health Action Plan would have been very important. Not only would the plan have benefited, but Sierra Leone's next generation of health care workers could have been inculcated with a new way of approaching their nation's problems.
VI. DISCUSSION

The type of health reform in Sierra Leone is another example, from international comparisons, of a broad based sector approach to investment. As defined by the World Bank, this approach includes six features: (1) it is a sector-wide investment program which covers all sector expenditures and activities; (2) it is based on a clear policy framework (the National Health Action Plan); (3) local stakeholders are fully in charge; (4) all main donors must sign-on to, and finance the approach; (5) implementation arrangements are as much as possible common to all financiers; and (6) local capacity is relied upon for the project. Sierra Leone’s initiative satisfies these criteria, especially as a wide range of local stakeholders have initiated and structured this program, using a broad view of the entire Sierra Leone health sector, and have mandated that donors, NGOs and others, operate within this framework. Sierra Leone will be a key test of whether this approach can improve upon the past performance of older, project-oriented strategies. Although this paper has not focused on the nature of sector-wide approaches, the key point is that this approach has provided a framework that enabled government to undertake wholesale health sector reform.

Given the relative progress of Sierra Leone’s reform effort, we can define other factors whose presence allowed the reforms to happen. While the context is specific to Sierra Leone, many of the factors involve management of processes and stakeholders that would be helpful in any context. Other factors beyond these may also be present, and their identification may require deeper investigation of Sierra Leone’s ethnic cultures. The outside observer may fail to see more subtle nuances in this reform effort which are based on local and tribal dynamics. But for most observances, six factors stand out in the areas of the role of key stakeholders and processes,
notably: (1) strong leadership; (2) broadening the arena of stakeholders; (3) managing the donors; (4) moving toward a task culture; (5) clear prioritization; and (6) the celebration of success.

**Strong Leadership**

It is doubtful that much of this could have been accomplished without full political support from the top. The Secretary of State for Health has shown himself to be a highly skilled negotiator who has been able to obtain more latitude and resources from his own government while obtaining assistance from abroad. His original idea of a National Health Policy has also been reinforced by his discussions with the then Nigerian Minister of Health. During the process, as task teams have formed, other leaders within the DOH have emerged.

The political context in Sierra Leone ironically opened the way for health sector leaders to be able to exercise their “will” to further public interest.22 In contrast to situations where leaders seek to protect their power, either as a group (e.g. political party) or as individuals, it became clear that the leadership in the DOH were not being driven by these interests (even if there had been doubts that the military government would hand over government to civilians). Of course, the interests of particular constituencies and individuals still needed to be addressed during the reform process. Nevertheless, the clear time limitation on the political leadership in the DOH gave it credibility, and allowed the DOH to pursue a technical approach while engaging a broader range of stakeholders to more genuinely public pursue reforms.

Despite its limited duration, the stability of the leadership of the health reform effort was also critical. In Sierra Leone, the political leadership was virtually constant for four years. The current DOH leadership also includes many professionals who have served in that agency for
many years. Fortunately, the new government resisted the purge of the old cadre and has been able to maintain a stable team in place at DOH. By balancing “new blood” with old, the reform effort has benefited from both fresh ideas and critical institutional memory. Political leaders would do well to heed this, especially in the countries where the leadership of major agencies often turns over several times within a President’s term, and where elections are excuses for a complete leadership turnover, preventing reforms from taking hold.

**Broadening the Arena of Stakeholders**

One of the successes of this effort has been the inclusion of more stakeholders and actors than before. Through interviews, surveys, focus groups, mass meetings, task forces, workshops and other methods, literally thousands of Sierra Leoneans have been involved in setting the reform agenda. The rural and urban poor, practitioners, low and mid-level bureaucrats, male and female chiefs, the national woman’s movement, and many others have, for the first time in memory, been consulted on these plans. Not only is the agenda probably more responsive to real needs as a result, but expectations and support for health reform have also been boosted.

Health reform and planning exercises often seem to take place in secret. The health reform effort in Sierra Leone has been remarkably transparent. Working groups were used to draft them, citizens across the country were informed of them and asked their opinion, and various landmarks in the course of the initiative have been publicly announced. In this exercise, the “public” was the lay citizenry as well as the middle and lower echelon of the bureaucracy, which is frequently the last to know what its leadership is planning.

This public process has three benefits. First, the priorities and strategies to be used bear some semblance to the expressed wishes of the public. That should speed their implementation.
and, hopefully, their success. Secondly, the public is now aware of these plans, and has heightened expectations around them. New constituencies have been created. Third, the reform agenda really has been modified in response to a public process. Its priorities have shifted from the curative to the most basic preventive clinical and environmental services. This was a direct result of the public priority-setting process, and raises the credibility level of the reform effort enormously.

Managing the Donors

The artful management of the international donors has allowed the reform effort to remain locally owned, locally relevant, and coherent in its focus. By creating their own national health sector framework, Sierra Leone’s health reformers were then able to continue with their own agenda on their own terms. This has not always been easy. The creation of two separate reports on health finance commissioned by the World Bank and the World Health Organization respectively, is proof of how easily fragmentation can occur. That their respective reports seem to have been written in isolation from each other is also disturbing but not surprising. Donors have their own cultures, their own agendas, and their own ways of doing things. If left unmanaged, the best laid plans might be torn in different directions. If they are managed, they can be powerful financial and political allies.

Several developments point to early success in this area. At the May 1994 Social Sectors Roundtable in Freetown, the donor community agreed to work exclusively within the framework of the National Health Action Plan. Donor investments and assistance are being redirected so that program and geographic areas of greatest need are addressed. As a result, donors are now part of the DOH's overall activity planning. A common set of objectives is improving the
planning and monitoring for the sector, and cuts out the need for separate project implementation units for each donor. Duplication of efforts is being reduced, and donors are increasingly scheduling joint missions, and dividing responsibilities among themselves under government’s direction. Very difficult areas remain, such as rationalizing the various donor and GOSL accounting, procurement, disbursement, and auditing requirements. But progress has been made.

**Moving Toward a Task Culture**

Many of these exercises have forced the DOH to adopt some new behaviors. Teams of staff have gone to work solving problems and building consensus. They have had to operate under more formal rules and with decision-making based more on logic and less on political influence. The result of this is a national plan which reflects fiscal and health realities and which ties problems closely to strategies (something often lacking in other nations’ health plans). This has begun to move the DOH from a “power” culture to one based on “task” while greatly increasing its own internal self-confidence.

The most concrete example of this shift has been the development of 38 health sector performance indicators. These indicators include measures of “inputs” to the sector, processes, “outputs,” and clear outcomes. These are to be monitored regularly through a variety of existing and new mechanisms. Examples of certain indicators are given in Table 2. Using these indicators, the DOH has performance-based criteria that will drive it further towards a task culture.
### TABLE 2. SELECTED HEALTH PERFORMANCE INDICATORS

<table>
<thead>
<tr>
<th>Type of Measure</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Input</td>
<td>Health budget as percent of GOSL budget</td>
<td>5.2 (1993)</td>
<td>Annual Budget Submission</td>
</tr>
<tr>
<td>Output</td>
<td>Percent of 1 year olds fully immunized</td>
<td>35 (1994)</td>
<td>Cluster Survey</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Infant mortality rate</td>
<td>135 per 1,000 (1992)</td>
<td>National Household Survey</td>
</tr>
</tbody>
</table>


### Clear Prioritization

Creating a set of clear priorities can be one of the most difficult tasks in beginning a reform effort. Lack of information, competing stakeholder interests, and an inability to differentiate outcomes from processes can all impede prioritization. It is especially hard for government to do this, because a publicly accountable entity has to not only state its priorities, but also defend its decisions to omit specific items from this list.

There is no one best way to set priorities. Highly quantitative tools, like disability-adjusted-life-years, are useful for educating policy-makers and beginning discussions. They are, however, extremely dependent on a very medical approach to illness and often are inaccessible to communities. Nevertheless, they can help focus attention on broad areas and help communities and policy-makers shy away from other areas in which the “burden” of disease is much less. Other techniques (surveys, focus groups, structural interviews) are much more subjective, but can help create a set of priorities which are culturally more relevant while, at the same time, those whose opinions are elicited are educated about the initiative.
Sierra Leone has essentially combined all of the above. It has also committed itself to lengthy, positive processes. Options have always been presented fairly and openly with open debate around their selection. Priorities have been selected because of their relative importance, not to devalue the alternatives. The DOH has also been willing to make very difficult political decisions, so its priorities reflect real community need rather than political clout.

**The Celebration Of Success**

Ailing organizations often fail to mark their successes. Instead, they overemphasize their failures and ignore their “wins.” The DOH and GOSL have avoided this and, in doing so, have significantly raised the internal morale of the reform effort. The Heroes Day Award and the public launching of the National Health Action Plan by the Chair of the Ruling Council are two examples of public celebrations which bureaucracies too often avoid.

**VI. CONCLUSIONS**

Failure to identify the practical elements of reform may lead to several problems. First, reform efforts often omit one or more of these elements with predictable effects. The lack of community consultation is one example. Many of the best-conceived plans for bettering health services founder because they are developed in secret without the creation of any constituency. Second, the direction or thrust of change in one element can often run directly counter to change in another. For instance, the creation of a larger primary care physical infrastructure may be undermined by a financing scheme which places a premium on tertiary services. This has been
the case in numerous health systems where the need for primary care has been espoused while all the economic incentives worked in just the opposite direction.

These six critical success factors discussed above underlay the success to date of the Sierra Leone reform effort. While other developments outside the health sector will clearly affect the future of this initiative, Sierra Leone’s health reforms have a good chance of progressing if these factors can remain in place. The loss of any one of them (e.g., change in DOH leadership, slippage in the movement to a task culture, the closing of public communication) could threaten its success.

There are now several pending GOSL decisions whose outcome will determine whether these elements remain viable. Most troublesome has been the delays in the delegation of personnel authority to the DOH and in the upgrading of compensation levels. Without these steps, the fragile beginnings of the task culture may be defeated.

These factors may also be generalizable to other efforts in nations at various stages of development. The loss or absence of these factors has spelled doom for efforts in other parts of the world. Various failures in individual states in the United States provide one set of examples. The inability of many low income countries to openly redirect health spending is another. The economic conditions may be wildly different, but the critical factors for success in what is a very political undertaking will be very similar.

The presence of these factors may also be useful in predicting the outcome of reform efforts. The World Bank, for instance, may wish to carefully weigh whether it wants to join a reform effort in a country where the entire DOH management team is inexperienced, priorities are set behind closed doors, and different donors are doing very different things. Every situation
will always require its own special, somewhat subjective analysis. But the absence of several of these success factors should be a signal for caution.

The presence of these factors may also change over time. For Sierra Leone, one of the great challenges will be maintaining public and community participation as it goes forward. So far, it has done a good job. But the DOH’s plans for decentralization of decision-making to districts include very little emphasis on that community role. Where it is mentioned, it is mostly to cast the community as a passive recipient of health education. Sierra Leone has done a lot to actively involve its people in this process; it must not now abandon this principle.

The DOH may well want to consider formalizing their public process. While this risks the creation of a bureaucratic, “captured” vehicle, it may also be the only way of making sure some two-way public communication continues. One method would be to create formal standing advisory boards at every health facility, with representatives from local consumers, health care practitioners, the administration, and other stakeholders. Such a structure could also be created at the district level. Another method would be to create a public hearing meetings in its region each year, to communicate its plans to the public, to gather its response, and to report to the Secretary of State for Health each year.

The role of stakeholders will also evolve over time. To date, the major stakeholders have either worked for government, or otherwise had a direct stake in it. This includes the DOH, the GOSL, the existing elites, the chiefs, and most of the health professionals. Should the reform agenda progress, however, it may begin to create new demands for empowerment and control from one critical group: doctors. To date, the government has been able to treat them almost as another class of employees. Should the reform agenda attempt to correct the maldistribution of physicians in Sierra Leone (see Figure 5) by deploying them, they may choose to become much
more active and resistant. Conversely, as Sierra Leone’s health sector becomes more sophisticated and more privatized, the dynamic may also change. The emergence of a more affluent, independent set of health professionals may come very quickly. Their demands for recognition, income, and entrepreneurial opportunity may become very difficult to resist. The growth of this private sector may have the promise of reducing state subsidies to the elites, but it may also skew national priorities towards the higher-technology curative services this nation can ill afford.

FIGURE 5

![Distribution of Government Employed Physicians in Sierra Leone (1994)](image)


The local consumer elites will also change over time. So far they, too, seem to have been relatively passive. That will change if they have reason to fear that resources will be redistributed away from them to more rural, poor populations. Should their incomes rise, and should they witness significant new public investment in health, their demands will increase. Those demands will be for government-paid tertiary care. The management of these elites and their natural physician allies will be perhaps the greatest test of Sierra Leone’s reformers.
By developing and implementing the NHAP, Sierra Leone's reformers are taking significant risks. A narrower approach would certainly produce short-term visible results. For example, a targeted campaign against diarrheal diseases might demonstrate better outcomes in a relatively brief period. The GOSL and DOH could thus secure a "win," though they would have done little to address the structural problems in Sierra Leone's health care system. By trying to reform all of Sierra Leone's health sector, the reformers are looking for more lasting improvements at the risk of not showing immediate results. It is a wise, but somewhat hazardous strategy.

The progress, to date, of Sierra Leone's efforts raises the recurrent question of whether reform is possible or even advisable without a sound macroeconomic base. The long-term sustainability of Sierra Leone's health reforms may well depend on an environment in which deficits have been made manageable and inflation has been controlled. The severe deterioration of the nation's health infrastructure during the general economic decline of the 1980's shows the damage that this sector can incur in the context of broader fiscal problems. Not only is the health sector's financial health dependent on macroeconomic conditions, its successes also depend on the performance of other sectors. As an example, without improvement in transport, it will be impossible for Sierra Leoneans to have access to newly developed primary care facilities.

None of this should be used as an argument to do nothing before macroeconomic conditions are secured. A sound macroeconomic base may be necessary for sustainability of reform, but it should not be a precondition for reform's initiation. As long as the government has committed itself to a workable allocation of sector resources (as the GOSL has done) reform should begin. Short-term progress can raise expectations and show promise before all the macroeconomic indicators are right. These projects are so time-consuming, and delay so
common, that the sooner planning and even pilot implementation begins, the better. Indeed, delaying sector-wide planning and reform will only allow the continued proliferation of uncoordinated categorical projects. While some would argue that this early sector-wide approach is premature in that government would not have the capacity to implement reform, the Sierra Leone example also shows how reform can indeed help government to develop that capacity.

Sierra Leone has come a great distance in only three years. There are many challenging issues yet to be resolved, but it has started a reform process that puts them in a better position to deal with them. It now has one of the most structured health reform efforts of any developing country. This has been done mainly with local initiative and resources while the donor community has been allowed to help when appropriate. The future success of Sierra Leone may hold important lessons for efforts in other nations.
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