BY-NC-ND

INNOVATIONS FOR
SUCCESSFUL SOCIETIES

A PROMISE KEPT: HOW SIERRA LEONE'S PRESIDENT INTRODUCED FREE HEALTH CARE IN ONE OF THE POOREST NATIONS ON EARTH, 2009 - 2010

SYNOPSIS

When Ernest Bai Koroma assumed the presidency of Sierra Leone in 2007, he promised to run his government as efficiently as a private business. A few years earlier, a brutal 11-year civil war had ended, leaving an estimated 50,000 dead and an additional two million displaced. The effects of the war gutted the government's capacity to deliver basic services. Koroma launched an ambitious agenda that targeted key areas for improvement including energy, agriculture, infrastructure and health. In 2009, he scored a win with the completion of the Bumbuna hydroelectric dam that brought power to the capital, Freetown. At the same time, the president faced mounting pressure to reduce maternal and child death rates, which were the highest in the world. In November, he announced an initiative to provide free health care for pregnant women, lactating mothers and children under five years of age, and set the launch date for April 2010, only six months away. Working with the country's chief medical officer, Dr. Kisito Daoh, he shuffled key staff at the health ministry, created committees that brought ministries, donors and non-governmental organizations together to move actions forward, and developed systems for monitoring progress. Strong support from the center of government proved critical to enabling the project to launch on schedule. Initial data showed an increase in utilization rates at health centers and a decline in child death rates.

Michael Scharff drafted this case study on the basis of interviews conducted in Freetown, Sierra Leone and London, U.K., in September and October 2011. Case published February 2012. See related cases, "Turning on the Lights in Freetown, Sierra Leone: Completing the Bumbuna Hydroelectric Plant, 2008-2009" and "Delivering on a Presidential Agenda: Sierra Leone's Strategy and Policy Unit, 2010-2011."

INTRODUCTION

In March 2010, Sierra Leone's president, Ernest Bai Koroma, undertook a nationwide helicopter tour to evaluate progress on a national health-care initiative. The government planned to launch free care for pregnant women, lactating mothers and children under five years of age in less than a month, but the tour revealed that repairs to health centers were behind schedule. The delays threatened to derail plans.

The president convened a meeting at his home with his advisers, health staff and the heads

of donor groups, and threatened to fire everyone if the delays continued. Ultimately, he did not fire anyone, but to those seated in his living room, the threat highlighted the president's personal investment in the project and his commitment to success. Just six months earlier, most people in the room that night would never have imagined that Sierra Leone could organize free maternal and child health care, at least not so soon—or that the main champion would be the president himself.

When he came to office in 2007, five years after an 11-year civil war left an estimated 50,000 dead and two million displaced, the then 54-year-old Koroma, a former insurance broker, promised to bring business efficiency to his government.

One of his first priorities was to develop Sierra Leone's second Poverty Reduction Strategy Paper, a template for national development, drafted on the basis of conversations with government officials, national civic leaders and aid donors every three years. The strategy paper, which Koroma labeled his "Agenda for Change," emphasized progress in energy, agriculture, transportation, education, health and other social services. Koroma focused on the needs of ordinary citizens.

With government capacity low in the wake of the war, Koroma found it difficult to make progress on his agenda. The war had destroyed much of the country's infrastructure and displaced government workers, leaving ministries and departments without skilled employees. In August 2009, Koroma was striving to complete the Bumbuna hydroelectric dam, which was to provide the capital with its first reliable power source. The effort to improve electricity supply had dragged on for years, beset by a lack of coordination among government ministries and contractors. In an attempt to overcome capacity problems in the ministries, the president established a special advisory group that provided him with strategic advice on how best to drive key projects through ministries. With the help of Victor Strasser-King, a Sierra Leonean who served as head of the group, Koroma's government was just months away from finishing the dam project.

A series of events created an opportunity not only to take some of the lessons emerging from the Bumbuna experience and use them to improve health care for women and children, but also to improve coordination at the cabinet level, in the center of government. This case chronicles the innovations a reform team led by Dr. Kisito Daoh, the chief medical officer in the Ministry of Health and Sanitation (hereafter referred to as the health ministry), put in place with the president's help. The case demonstrates how the innovations improved both cabinet effectiveness and made progress in providing better health services. Between August 2009 and April 2010 when the president launched the program, the team created structures and processes for defining priorities, generating action, monitoring progress and coordinating efforts by ministries and agencies—all of this in a government that had few highly trained or experienced managers or technical staff. The team also developed a creative way to engage and coordinate donor involvement.

THE CHALLENGE

As 2009 began, the urgent need to improve maternal and child health care in Sierra Leone was clear, but the country seemed poorly positioned to respond. Sierra Leone ranked worst in the world for both maternal mortality and infant mortality. At the time, the risk that a woman would die during childbirth at some point in her life was one in eight. One in 12 newborns died within a year. Data showed that cost deterred women from seeking care or bringing their children for treatment, and there were few grounds for optimism. In 2002, the health ministry had attempted to launch a free health-care program without first addressing

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

fundamental challenges to the health sector, such as the low salaries and lack of medical supplies. The initiative quickly fizzled. In 2005, Sierra Leone had eliminated user fees yet again, but the government, weakened by the prolonged conflict, could not enforce the law. Informal fees charged by health workers replaced formal fees, and the law did not provide for free medicines, which discouraged people from seeking care.

Despite the setbacks, advocacy groups continued to press for action. At the same time, policy makers in other parts of the world had begun to worry that African countries would fall far short of reaching Millennium Development Goals—concrete targets, including improvements in child and maternal health, that U.N. member states agreed to achieve by the year 2015—and urged free health care for women and children. They wanted Sierra Leone to join with Burundi, Zambia and other countries in abolishing user fees.

When it came time to sign performance contracts with his ministers in early 2009, President Koroma, sensing the importance of the issue, put making health care free for pregnant women, new mothers and young children in his health minister's contract. The actual wording in the contract, however, included few specifics on how to deliver on this charge. Many other priorities competed for the president's attention, and a year and a half after he assumed office, the president still had focused little attention on the issue.

A series of events created an opportunity to attempt, yet again, a free health-care program. In the summer of 2009, Koroma's health minister, Sheku Tejan Koroma, who was not related to the president, found himself in hot water. The country's independent anti-corruption commission, which the president established upon taking office, had started to investigate whether Tejan Koroma had abused the powers of his office by steering contracts to business associates. Possibly to counter the whispers in the ministry corridors, the health minister called an emergency meeting in the first week in August. He gathered his senior staff and about a dozen donor representatives, and told the group that he wanted to make health care free for pregnant women and children.

His proposal attracted enthusiasm from international aid agencies and non-governmental organizations. However, worried that a flood of visitors could inundate health centers if the initiative were not properly planned—and well aware of past failures to launch free care—international experts urged the minister to delay implementation until the ministry formulated a strategic plan.

The health minister called on Daoh to help create a plan of action. Daoh had been a clinician in Sierra Leone in the 1980s and rose through the ranks at the health ministry, eventually becoming head of reproductive health and then chief medical officer. He was an invaluable leader within the ministry. "Dr. Daoh made the difference in the ministry," recalled Francesca Pacitti, a former adviser with the Africa Governance Initiative (AGI), a nonprofit organization headed by former U.K. Prime Minister Tony Blair. "He would have his team in his office every morning at 8 a.m. You couldn't do something like free health care just from the top. You needed people in the ministry."

Daoh gathered the heads of the health ministry's eight directorates and sought counsel from development partners.

These developments attracted the notice of others. Following the health minister's announcement, the international community hoped that Koroma would use the meeting of the United Nations General Assembly, scheduled for late September 2009, to formally announce the program. Although Daoh and his team had begun exploring details, free health care was not yet policy, and advocacy groups continued to push

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

for action. Just before the U.N. meeting, Amnesty International published a report that declared Sierra Leone's poor maternal and child health performance "a human rights emergency." The president stopped short of making an official announcement at the U.N., but he did join five other heads of state in expressing a commitment to developing free health-care systems for pregnant women and young children, a move which indicated to ministry staff that the head of state was serious about sustaining the momentum begun with the health minister's declaration.

To make the free health-care initiative work, Daoh and the president would have to confront several weighty challenges. Sierra Leone lacked a national health plan or other statement of health priorities. A plan didn't guarantee success, of course, and in many places ambitious visions exceeded capacities. But without a statement of concrete objectives, a list of the implementation steps and a timetable, ministers could not manage resources effectively. The press of everyday business impeded government progress on some of the objectives that mattered most. In turn, without a plan, it was difficult for a ministry to coordinate at the center of government—for example, to act on promises a president or prime minister made to the public or promises that emerged from a national consultation. The ministry had developed a basic maternal and child health strategy in 2008 under external pressure, but it had gone no further.

A national health plan also would have provided an opportunity to coordinate foreign assistance and the activity of non-governmental organizations. When the president announced his plan in November 2009, a number of projects, funded by various donors with differing deadlines, were under way to improve aspects of the health sector. Donors often approached the health ministry individually about funding initiatives. For example, the World Bank funded a drug-procurement process that was different from the health ministry's process, which meant that the ministry was often unaware of what drugs the World Bank was ordering. Another challenge was that sometimes donors supported non-priority projects for Sierra Leone, and the projects and consultation took up very scarce staff time.

If lack of focus was one problem, mobilizing staff members to deliver services was another. In the capital city, Freetown, with a population of two million, fewer than 180 government health workers had been trained to deliver babies. Around the country, there was just one doctor for every 33,000 people.[1] The World Health Organization recommended a minimum doctor-to-population ratio of 1:12,000. Six of the country's 13 districts offered no emergency obstetric care, preventing women in these districts from receiving potentially life-saving caesarean sections or blood transfusions.[2] Health staff who did appear on the job were often under qualified.[3] According to Daoh, 90% of the trained doctors under his supervision left the country during the war.[4]

Although Sierra Leone lacked trained doctors, there were other health workers who wanted jobs, but the government had little money or administrative ability to support new hires. Even though they were not on the payroll, some of these lower-level practitioners still provided care at health centers, where they collected fees directly from patients.

In addition to lacking capacity to hire staff, health centers were often underequipped and in need of basic supplies. "We didn't have the facilities. We didn't have the drug supplies," Daoh told an online newspaper in 2011.[5]

Weak internal management within the health ministry interfered with the ability to transport supplies to the right locations and ensure that nurses, doctors and officials were at their posts, doing their jobs. "Some people were just not showing up to work," said Erin Chu, an international consultant hired by the U.K.'s

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

Department for International Development (DFID) to work on human resources management issues. Some employees worked tenaciously, while others slacked off. Health staff pocketed patient fees to supplement their meager salaries, which, according to Rob Yates, a senior health adviser with DFID, "were some of the lowest in all of West Africa." Muhamed Koroma, director of corporate strategy and administration at the Human Resources Management Office, who was not related to the president, said that before the launch of free health care, a registered nurse in Sierra Leone earned about US$57 a month. He noted that a registered nurse in Gambia made more than three times as much, US$182 a month.

The ministry's headquarters in Freetown lacked running water and, despite progress on energy issues, power sometimes went off without warning. Susan Mshana, a health adviser with DFID in Sierra Leone described the ministry as "initially a grim place to be." Another visitor observed, "There were chickens living in the women's bathroom, and there was total confusion. No one knew what they were supposed to be doing. People would just be sitting at their desks reading newspapers. There was no accountability."

The vehicles for interaction or collaboration within the health ministry were few, and any effort to improve health care required coordination with other ministries. For example, the Human Resources Management Office—an extension of the President's Office—employed health ministry staff members. Money for health ministry salaries and materials came from the Ministry of Finance. The Accountant General maintained the health ministry's balance sheet. The Sierra Leone Port Authority had control over the main port, through which medicines passed. Solutions to many public health problems required collaboration with the health ministry. Clinics needed electricity and other types of infrastructure. Therefore, to act on the president's promises, health officials would have to work with the Ministry of Energy and Power and the Ministry of Works and Infrastructure. The program also required actions within the jurisdiction of the Ministry of Foreign Affairs and International Cooperation, the Ministry of Information and Broadcasting, and the Ministry of Internal Affairs, Local Government and Rural Development.

The free health-care initiative presented both risks and opportunities for the president. Koroma could score a quick political win at the launch, but continued success of the program would require a sustained commitment. By the next election in 2012, much could go wrong. At the same time, the initiative was valuable politically because it had broad impact in a country where ethnic and regional loyalties often cast suspicion on projects that had narrow benefits for certain groups or areas. The nationwide program had the potential to affect all people equally and therefore undercut opposition claims that Koroma delivered services based on political considerations.

FRAMING A RESPONSE

In August 2009, knowing he had to move quickly after the health minister's announcement, Daoh reached out for advice and guidance. He enlisted the help of Faye Melly, who at the time was an adviser with the Africa Governance Initiative (AGI), and had joined the ministry in April, to lay out the next steps.

Working closely with DFID, Daoh and Melly began by creating technical committees to develop a strategy. Each committee addressed specific issues and included donors, staff from non-governmental organizations, officials from related ministries, and health ministry managers. Healthy debates ignited about the grounds for eligibility, vouchers, insurance and other matters.

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

In early October, the president told Parliament that his government had initiated innovative responses to the maternal and child health crisis. The following day, Daoh convened a one-day workshop at which the technical committees shared their work and collectively agreed on key aspects of the initiative. Daoh then assigned a subcommittee to formulate a strategy document based on what was agreed upon. Melly provided advisory support for the subcommittee, which included Daoh and Dr. Samuel Kargbo, the health ministry's director of reproductive and child health.

Before his health minister's announcement, President Koroma had expressed interest in developing a national health insurance program in addition to free health care for pregnant women and children. But such an insurance program would require people—except the very poor who were able to obtain waivers—to pay into the system. Mothers and children were dying because they did not have money. The health ministry submitted its strategy, which did not include an insurance component, to the president in late October. Upon reading the strategy document and hearing from excited donors, Koroma threw his full support behind the free maternal and child health program, which stood to make a greater immediate contribution toward the Millennium Development Goals than an insurance program.

In a November 2009 speech at a donors' conference in London, the president officially unveiled the free maternal and child health program and announced a launch date of 27 April 2010, setting the aggressive six-month timeline in order to have the initiative culminate on Sierra Leone's Independence Day. Under the program, pregnant women, breastfeeding mothers and children under five years old would be able to visit any government health facility in the country for any kind of treatment and not pay a single Leone, the local currency. Based on the average number of women pregnant at any point in time, health ministry staff estimated nearly 230,000 pregnant women and about one million children stood to benefit from the initiative annually.

Money was an issue on everyone's minds, as the government of Sierra Leone could not fund the initiative alone. Gordon Brown, the U.K. prime minister at the time, had put improving health in Sierra Leone high on his government's foreign-aid agenda. The Government of Sierra Leone's own research showed cost as the greatest barrier to getting care, and Brown wanted his government to support the elimination of user fees as a means to lower maternal and child death rates. Brown also stood to gain politically from supporting Sierra Leone's efforts, as the U.K. people supported providing assistance to Sierra Leone. Since its independence from Britain in 1961, Sierra Leone had maintained strong relations with its former colonial ruler. That relationship was evident in 2000, when British armed forces intervened in Sierra Leone's civil war and helped to bring an end to the fighting.

Senior political figures in the U.K. worked closely with DFID to build support for Sierra Leone. Development partners estimated the total cost of delivering the initiative in 2010 would be US$91 million. This figure included the cost of increases in health workers' salaries, drugs and medical supplies, logistics, medical infrastructure and support for monitoring and evaluation.

Some donors were split over the best way to help. "There was an ideological divergence over how it would be done," recalled Andrew Felton, DFID's former deputy head of office in Sierra Leone.

The World Bank, already a donor to the health ministry, emerged as a critic of the plan to eliminate health-care fees, arguing that such a move would lead to greater dependence on donors and less local ownership of the process. The bank believed that fees increased the efficiency of

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

government health services by reducing frivolous demand for services, and generated additional revenue for the health sector. Furthermore, the bank did not believe Sierra Leone was yet capable of funding its health sector from its own sources.

But the free health care initiative was not just about getting rid of informal fees but also about using the opportunity to reform the broader health sector, including improving the quality of services and developing the drug supply chain. In 2010, after prodding from the U.K. government, the World Bank dropped its support for fees in Sierra Leone.

By the time of Koroma's November announcement, pledges totaled US$70.9 million and included commitments from U.N. organizations like the World Health Organization, various NGOs, the Global Fund (a public-private partnership funding prevention and treatment of AIDS, tuberculosis and malaria), the GAVI Alliance (another public-private partnership focused on children's health issues), and DFID. Although this figure was still short of the estimated US$91 million cost of the project, an estimate based on what an ideal program might cost, the shortfall did not prevent the government from moving forward with its plans.

Koroma's announcement jolted people into action but also raised eyebrows. Free health-care systems had been set up in countries around the world, including in Africa, with varying degrees of success. Even the president's most ardent supporters were unsure whether Koroma could deliver on his promise.

People had good reason to be skeptical. The health ministry had not worked well in the past, and it was now leaderless. Koroma had fired his health minister, who was under indictment on corruption charges, the day before the international meeting at which the president announced the commitment. Moreover, to make the program work, policy coordination across ministries would have to improve.

GETTING DOWN TO WORK

Koroma's first step was to name the vice president, Samuel Sam-Sumana, caretaker of the ministry of health. The move signaled to people that the president was serious about implementing the initiative. "Putting his vice president in charge of the health ministry underpinned how much importance the president placed on this," said Susan Mshana, a health adviser with DFID in Sierra Leone.

Next, the president had three objectives: to assemble decision makers and figure out specifically what was needed to make the program work, to solve coordination problems, and to develop a system that made more prudent use of his own time.

Committees and coordination

At the suggestion of Daoh and the vice president, Koroma put a new kind of coordination system in place, modeled loosely on the delivery unit model in the U.K., which monitored and supported government institutions to carry out the Prime Minister's priorities. Working with the president, Daoh created a tiered committee system that explicitly included staff members from key ministries and donor representatives, bringing all the relevant people together in one room on a regular basis. Technical committees would move action forward and address minor issues, while a steering committee would address bigger problems and forward information to Koroma when the president's attention was required. The steering committee focused on priority setting and review. The system would address several of the challenges the new program posed, including internal management, interministerial coordination and donor engagement.

Daoh created technical committees for infrastructure, finance, drugs and logistics, monitoring and evaluation, human resources and communications. A representative from the health ministry along with a representative from

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

an international development organization, co-chaired each committee. Staff members from other ministries sat on the committees where the work of the group was relevant to their ministry. Non-governmental organizations that had a role to play also sat on the committees.

Monitoring was important to ensure that things got done. The Bumbuna hydroelectric project, which had just come on line, had introduced the use of trackers to keep tabs on progress of specific action items. Trackers, simple spreadsheets created with off-the-shelf software, listed key priorities, the status of work on the priorities, and the ministries and individuals responsible for delivery. Trackers had helped the Bumbuna team organize and monitor key aspects of the project, and Koroma encouraged their use for the free health care initiative.

In November 2009, the health ministry gathered all of the new technical committees at a local hotel. In the dining room with sweeping views of the city and distant Atlantic Ocean, Daoh explained the reason why the committees were created and what he and the president expected of them. He instructed committee representatives to identify and list the top 10-12 things they needed to do. "Each one of the working groups faced a massive number of challenges," said DFID's Mshana. "Prioritization was very important." The priorities decided at this meeting became the basis for the priorities listed on each technical committee's tracker.

The committee structure also served as a way to accelerate specific projects and align completion dates under the banner of the free health-care initiative. To do this, each committee surveyed the work already under way in their sectors and formulated specific priorities for their trackers.

Each technical committee met weekly and reported to the steering committee, which Koroma asked Daoh to chair, with the vice president also present. The steering committee met every other week to monitor the progress of the technical committees. Finally, the president held monthly meetings for progress updates from the steering committee.

Temporarily, Melly acted as Daoh's aide. Before the steering committee meetings, she briefed Daoh on the top issues and priorities for the meeting. She provided Daoh with an annotated agenda, which showed the status of each of the issues up for discussion. "The steering group meetings were a very good format," recalled Daoh. "Information was shared and we discussed how we would overcome the challenges."

The co-chairs of each technical committee were required to present their trackers. Dr. Augustine Sandi, a medical doctor, and the co-chair of the human resources technical committee, said that when it came time to presenting his tracker to the steering committee: "We all sat together, we planned together, we discussed together and we took a common position together. It was quite a good setup." Melly recalled that at the steering committee meetings, "You had a pretty impressive group of people looking at the trackers and asking, 'Why the hell isn't this being done?'"

The steering committee expected the technical committee co-chairs to be clear on how the steering committee could best support their activities. "It was such a tight governance system that no one had anywhere to hide," recalled Melly. Meetings also promoted cooperation. "Getting something done wasn't on any one person. It was a partnership," she said.

As time passed, steering committee meetings became crowded affairs, reflecting the number of people who wanted to stay abreast of the latest planning and decisions. The health ministry did not limit participation, and representatives from U.N. agencies and non-governmental organizations, consultants, ministry officials and presidential advisers all packed shoulder-to-

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

shoulder in the health ministry's cramped conference room. "It was initially frustrating when the number of participants increased because people had not read previous meetings' notes and asked many questions that took us back to square one," said Melly. "But the positive side was that more people were engaged, knew about the government's plans, and, importantly, were proposing solutions for addressing implementation challenges."

The meetings could last as long as five hours. After the meeting, advisers from AGI would compile a one-page document on actions agreed upon at the previous steering committee meeting and the status of projects. The document also listed what the steering committee participants saw as potential risks and issues that could negatively impact on launch plans, and included space for staff to describe what mitigating actions they were taking to ward off potential trouble. This document formed the basis of discussion at the president's monthly meeting that served as the final link in the committee structure.

The presidential meetings brought together senior ministry officials and heads of donor groups and foreign missions. Mshana of DFID attended the meetings and recalled they were accompanied by "a lot of head banging by both the president and vice president." Typically, the issues brought to this meeting required the direct involvement of the president and his team.

Although the committees created formal channels of communication, behind-the-scenes discussions between donors and implementing partners, and with the president and his inner circle, helped decision makers respond before issues ballooned. For instance, Brian Gilpin, the president's personal assistant, briefed Koroma before the monthly presidential meetings. He kept an ear to the ground and could alert the president if he thought a committee needed extra prodding or supervision. Gilpin could also reach out to the committee co-chairs for clarification.

Daoh had an open line of communication with Gilpin. On multiple occasions, Daoh asked for private meetings with the president. "I requested meetings with the president to show him that I was on top of my stuff," Daoh said. The meetings strengthened the trust between the two leaders.

Mobilization and monitoring

At each technical committee meeting, attendees decided which of three colors—green, yellow or red—to assign to each action item on the trackers. Committee participants used red to signal that action items required the steering committee's review, often because work was behind schedule and needing help from senior leadership. Yellow signaled an optional review by the steering committee, and green marked action items that were on schedule and required no help. The tracking system required explanation in the early days because the colors were initially meaningless. Sierra Leone had only one three-color traffic light, and it did not work.

Initially, almost all technical committee actions were reactive, dealing with problems as they arose. However, the drugs committee enjoyed some success in thinking strategically about quantities of drugs and medical supplies. Its partner was UNICEF, which had experience in drug procurement, storage and distribution. UNICEF's staff members helped Sierra Leone partners review the experiences of other countries that had launched free health-care systems. They crunched numbers, reported the figures to the committee, and in January placed an initial order. "They were very intelligent estimates," Mshana said.

Although each committee had a list of responsibilities, committee personnel had not explicitly laid out how each would be accomplished. "Initially, we looked at the anthills

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

but not the ants," said Mahimbo Mdoe of UNICEF. Mdoe cited the example of the main drug storage warehouse in the capital. "The drug and logistic committee's tracker would have said, 'central warehouse to store drugs and medical supplies,'" explained Mdoe. "That was our anthill. But beyond that, no instructions were given as to specifically how to make that happen. There were huge challenges. The place needed to be refurbished, hooked to the central power grid, and inventory systems had to be set up. Those were the ants."

Staffing the initiative

"Our first reaction at the human resource office to the president's November announcement was, 'Do we have the manpower?'" said Muhamed Koroma. Based on the number of known health facilities and international guidelines on the proper doctor-to-population ratio, the health ministry had calculated that about 3,000 new health workers were needed to address widespread staff shortages.

Before they committed money to pay for new hiring, DFID officials said they wanted to ensure that employees listed by the ministry were actually on the job. It was an open secret that retired personnel, the relatives of staff members who had died, and staff who were working or studying abroad, often still collected pay from the ministry.

Coordinating the removal of former and delinquent staff from the payroll and the hiring of new staff fell to Human Resources Office, which worked closely with the other organizations that had a stake in the process including the health and finance ministries, the accountant general's office, and donors. The human resources technical committee provided oversight and ensured that efforts moved ahead.

In February, DFID hired the international consulting firm Booz & Company to assist the ministries. Erin Chu, the Booz team leader for Sierra Leone, said she was impressed with the caliber of the operation when she arrived. "The coordination and cooperation was amazing. People were really enthusiastic about making it work," she said. "There was a lot of energy." Booz representatives proposed a way to clean up the payroll and won the agreement of the ministries and the technical committee.

As a next step, health ministry officials assembled the top health officials from each district at a Freetown hotel and asked the district staff for support in cleaning the payroll. In a country that lacked reliable communications, the meeting offered the opportunity to inform the district personnel of pending changes to the health system, answer questions and allay concerns or misconceptions.

The Human Resources Office drew on three different sets of information to weed out people who were not working. First, the ministry had its own official payroll. Second, ministry staff got hold of a headcount the health ministry had done in late 2009. Ministry officials cross-checked the two sets of information. The officials took a conservative approach and, rather than delete names, flagged those that looked suspicious for the district staff to examine. The updated lists, by district, appeared on spreadsheets that were sent to the district staff at the Freetown meeting. To bolster the department's authority, Muhamed Koroma's team would write "The President's Free Health Care Initiative" on the top of the spreadsheets, and when giving instructions did not hesitate to reference the president. "During the payroll cleaning process, the ministry staff warned the district staff to report accurate figures because 'Pa' would be checking," said Chu, citing how some referred to Dr. Daoh and the president.

The district staff worked with staff at the health centers to gather the data, and sent their updated lists back to the Human Resources Office. Did opportunities exist for district staff to fudge the results? "Of course," said Chu, "but in this rapid type of situation you just needed to trust

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

people to do their jobs." Chu said initial estimates were that about 850 people who were not working were still on the payroll.

Next, the ministry referenced the district lists and compiled a single list and flagged questionable individuals. The nearly complete list then went to the health ministry, where Daoh had the ultimate say as to which individuals would have their pay frozen. In the case of freezing people's pay, Daoh consulted with the accountant general's office and the Ministry of Finance to ensure that payments stopped. People could appeal Daoh's decision to remove them by visiting the Ministry of Health in person, but few did.

Expanding the number of health workers was the next step after non-workers were eliminated. The director general of the Human Resources Office assigned Muhamed Koroma to lead the recruitment drive. Using radio and newspaper ads, the ministry announced its plans to hire and said it would send representatives to each district to interview applicants. People who wanted to compete for the jobs had to prove that they held proper diplomas and complete a formal interview. If they passed both steps, they were hired on the spot. There was no time to double-check the validity of the diplomas. "Because of the nature of the situation we had to break a lot of regulations," conceded Koroma, noting that he struggled to ensure that all hires were qualified to do the jobs they were hired to do.

But there was more. "I was instructed to recruit only 3,000 new staff, but I returned to Freetown having hired 5,800 workers," said Koroma. He said the health ministry's data undercounted the number of actual health facilities and therefore the recruitment figure was too low. Koroma's boss had given him permission to increase the number of recruits. But Koroma's actions angered other senior ministry officials. "At that time, the Human Resources Management Office had an incentive not to hire more people," Koroma explained. "The bigger the payroll, the more people that would be sharing from the salary pot, and the government had yet to contribute any money." Donor commitments from the previous November covered only the 3,000 hires that had been planned originally. The donors, said Koroma, "were not upset. They inquired as to why I had hired so many people, and I gave my explanation. They were pleased that the entire country was now being covered with health staff." DFID offered additional funds to cover the extra staff.

The president closely monitored developments in cleaning the payroll and hiring. Because the success of free health care hinged so much on having enough health staff to care for patients, he decided to hold monthly meetings at his office to track progress. These meetings were separate from the monthly presidential meetings that were a part of the committee structure and afforded the president opportunity to become more involved in critical issues.

Managing expectations

The president knew that scoring a political victory meant winning citizen support. Managing the public's expectations required an effective communications strategy. The communications technical committee coordinated the effort to convey two important messages: first, that the government intended to launch a free health-care initiative, and second, that the initiative was permanent and would not fold after a few weeks or months. The second message sought to prevent a crush of visitors to health centers immediately after the launch.

"People wanted to hear President Koroma's voice on the radio," Melly said. "He was the only one who could really get the message out there and convince people of the legitimacy of the initiative. So we knew we had to have his involvement." The communications committee worked with the president's office to put him on the radio and had him sit for multiple print-media

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

interviews. The committee also helped plan a tour for the chief nursing officer to visit all of the districts to spread word about the launch.

To manage the health ministry's day-to-day media efforts, Daoh turned to his trusted colleague, Dr. Samuel Kargbo. Gifted with a commanding voice, Kargbo was a powerful public speaker who relished the chance to go toe-to-toe with the media. He had a medical degree, a compelling background story—during the war he had ventured behind rebel lines to provide life-saving care—and he knew how to talk his way through tough topics, proving efficient at explaining the initiative and staying on message.

OVERCOMING OBSTACLES

The president relied on informal channels and quick thinking to navigate the initiative's biggest stumbling blocks.

Health workers' strike

At the end of February 2010, health officials, including Daoh and Magnus Gborie, the health ministry's director of planning and information, met with the vice president and Samura Kamara, minister of finance and economic development. They presented Kamara with a detailed proposal to increase health workers' salaries that adhered to Sierra Leone's 14-grade civil service pay structure. The proposal reflected salary increases based on three different scenarios: a 20% increase to each pay grade based on the salaries for 2009, percentage increases based on levels of qualification, and what health workers had requested in informal conversations with the health ministry. The health officials told the finance minister they were willing to increase salaries more than the first two scenarios but at a number less than the health workers had requested, which in some cases was five times what the workers were already earning. (The salaries the health ministry said it was willing to pay were grounded in part on initial donor commitments.)

At the time of the meeting, the finance ministry had already begun exploring ways to make broader reforms to public sector pay, which would entail restructuring the civil service pay scales and moving to a 17-grade system. The minister of finance asked the health ministry to align its proposal with the broader 17-grade system. Signaling the prominence of the free health-care initiative on the country's development agenda, officials also agreed at the meeting that, although public sector reforms would be phased in throughout 2010, they would start with the health ministry.

About two weeks after the meeting, the health ministry's plans were upended when health workers nationwide went on strike. Somehow, the health workers had gotten their hands on the salary proposal that Daoh and his colleagues had presented to the finance minister. The workers, realizing that the government was not prepared to pay them what they wanted and concerned that whatever increases they received could take the government months to pay, went on strike.

The strike had an immediate impact on the country as well as the ministry's plans. Health centers were left without staff, which may have contributed to deaths.[6] Some of the civil servants at the ministry were doctors, and they put down their work and rushed to attend to patients, which slowed efforts to plan for the launch.

President Koroma grasped the urgency of the situation and gathered his team in an emergency session. Events moved too quickly for the lengthy negotiations required to secure new aid commitments. When the president's aides proposed relatively modest increases, the strikers refused them. Koroma sensed he needed to confront the striking workers directly. The president's staff gathered workers in a sweltering auditorium in central Freetown, where Koroma

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

explained the reasons behind the changes and stressed how much he valued their contributions. Tensions rose when a handful of workers stood up and turned their backs to the president, a massive sign of disrespect.

Unable to make headway, the president, growing increasingly frustrated, told the striking workers that he was willing to sit down with their representatives, but only if the meetings were secret. Koroma was nervous that if word got out that he was personally negotiating with the striking workers, teachers and other public employees might also strike. Days later, he met with the heads of the doctors and midwives associations and some younger doctors at his home. Koroma told the group that his hands were tied. The government did not have the money. He asked them to accept the offer on the table, but the group refused.

Koroma knew he had to make it work somehow, despite warnings from the International Monetary Fund that increasing health workers' salaries might cause other public sector workers to ask for salary bumps as well. He discussed the problem with his minister of finance and proposed even greater increases. The minister told the president that the government could probably cover an initial one-month period with the higher wages, but no more.

At the same time, Yates, an expert on health financing, quickly put together a short document that he circulated among senior leaders at DFID, justifying why bold pay increases were appropriate given the current salary levels. DFID told Koroma they would help cover the increased salary costs for an initial period. With the launch less than a month away, and the strike in its second week, these assurances were all Koroma needed. He called the representatives back to his home and agreed with them on the revised figures. The president raised nurses' salaries from US$50 a month to US$250, and increased doctors' pay from US$250 a month to US$1,000, which brought the salaries more in line with neighboring countries. The government began paying the new salaries into health workers' bank accounts the day before the launch of free health care.

The increased salaries combined with the new hires meant the wage bill jumped from US$6 million to US$19 million. Because it took time for DFID to secure the additional financing, the government paid the April salaries at the new adjusted wages, plus back pay for March. Starting in May, DFID covered virtually every penny of the shortfall. It helped that Sierra Leone's minister of finance, a former executive at the World Bank, was trusted by the donor community.

Behind schedule

The protracted negotiations with the striking health workers had diverted President Koroma's attention away from other urgent matters, one of which was probing the reasons behind the slow pace of renovations and construction at health facilities, which he had earlier learned were behind schedule. Koroma wanted to see first-hand what was going on, and he set out on a helicopter tour of the country's health facilities.

Returning to Freetown after the tour, Koroma held a meeting with consultants and contractors responsible for constructing and refurbishing health facilities, including medical stores. Also present were the vice president, the deputy health minister, senior officials from the health ministry, and donors. The president was concerned that things were not getting done and admonished the contractors for the slow pace of progress. "I have done an on-the-spot inspection of these facilities," Koroma told the group, according to an official record of the meeting. "There is work in progress, and there is work to be completed. Commitments were made, promises were made." The president then demanded an update on progress in each of the four

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

geographical regions of the country. Officials provided approximations on when facilities would reach completion. The president threatened to blacklist contractors that did not deliver. "From that day until the day of the launch, we had daily meetings where we discussed progress on infrastructure projects," said Daoh. Most of the major renovations and construction were completed just days before the launch.

Drugs stuck at ports

A week before the launch, the central medical store had received only 20 of the 50 containers of drugs and medical supplies that had been ordered. The remaining 30 containers were locked behind the barbed-wire fence at the port. Some of the drugs were at risk of spoiling. The president called in representatives from the privately-owned port company and customs officials and instructed them to work with UNICEF to clear the containers.

There were two dominant issues. First, each container had a bill of landing and tax exception form that required the signature of multiple authorities including the ministries of health, foreign affairs and finance, and the national revenue authority. To get the signatures, workers had to pass the paperwork between the different ministries and agencies. This process could take as long as two months, after which the port had to conduct its own screening procedures. Along the way, the paperwork sometimes sat unnoticed in signatories' mailboxes. Other times it was misplaced. Second, the longer it took for ministry staff to sign the forms, the longer the containers sat in the ports, which meant the more fees the port operators charged. Koroma appealed to the port operators to waive the interest fees and set a 10-day limit for circulating the paperwork.

At the next presidential meeting about a month later, most of the containers still sat at the port, and, according to Mshana, "the president was furious." The president again insisted that the fees be waived. After the meeting, the president's office called the port operators and pressured them to release the containers. Days later, a long convoy of trucks snaked its way from the port to the central holding site in the capital. The military lent four trucks and multiple personnel to ensure the safe delivery of the drugs and supplies. "The movement of the 30 or so containers caused so much traffic it nearly shut down Freetown," Mshana said.

ASSESSING RESULTS

The sun had not yet risen on the morning of April 27, and already people queued in long lines outside of health centers around Sierra Leone. President Koroma's motorcade brought him to Freetown's Princess Christian Maternity Hospital, where he made his way to the podium. People waiting in line reached out to shake his hand. Speaking in the local language, Krio, he told those gathered before him that from that day on, pregnant women, nursing mothers and children under five would no longer have to pay to get care. Cheers erupted.

After the launch, the number of pregnant women and children visiting health centers dramatically increased. The average number of outpatient visits at health centers swelled from 367 visits before the launch to 1,375 one month after the launch. The mortality rate for May 2010 was 10%, which was an improvement over April's 13% and far better than the 18% rate for May 2009.[7]

The initiative saw a change in the relationship between donors and the government. Before the launch, donors often approached the health ministry individually with their own agendas. The free health-care initiative coordinated donor efforts around a project that the government wanted and led. The president's clear vision and strong political will guided the government's efforts to improve the country's health sector.

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

The overall outcome, however, hinged on the efforts of a core group of enthusiastic leaders who came together, agreed on a strategy to overcome the deficit in government capacity, and then followed through. "Free health care united all of the partners around one objective," said Mshana, and each played a unique role. For example, Daoh, by virtue of his position as the chief medical officer and head of the steering committee, was the linchpin and was supported by senior leaders at the other ministries. And AGI advisers helped reformers develop tools that enabled them to prioritize.

The committee structure proved critical. Prioritizing tasks made achieving results seem more manageable. "Before the committees, ministry staff just saw this huge monstrous problem," explained Mshana. "The committees helped to break down the issues into bite-size pieces that could be tackled. This helped to boost morale." With such a tight time frame, prioritizing helped keep everyone focused on the most important tasks. "We had to do in six months' time what normal policy processes would take five years to do," said Mdoe of UNICEF. "Six months gave everything a sense of urgency."

The committee structure also led to greater cooperation. The co-chair design stopped the cycle of donors going to the ministry, dictating terms and putting all responsibility on the ministry. Rather, the co-chair structure established mutual responsibility to see that priorities were implemented. "The co-chair structure promoted shared accountability of work," Melly said.

Importantly, the people who co-chaired the technical committees weren't just political personalities who owed their loyalty to the president. Rather, they were technical and operational experts in the areas they covered, which helped them win the respect of subordinates.

Koroma had only faint success in managing his schedule. Unexpected challenges during the planning for the launch required the president to react quickly. Brian Gilpin, the president's personal assistant, struggled throughout the pre-launch phase to strike a balance between involving the president in matters and trying to intervene on the president's behalf.

Although the committee design gave some structure to the flow of information, people often sought the president's authority to resolve even minor issues. Bombarded with requests, the president found it hard to determine where his intervention was really needed. As a result, many of Koroma's actions were more reactive than strategic. "His time was ad hoc and not always planned. He had to constantly react to issues that arose," Melly said.

Mdoe said the president sought to insert himself into the planning process only when it was most needed. Too much involvement by the president could have consequences. The UNICEF boss cited an example: "When he [the president] called the port operators and demanded the containers be released, he risked alienating ministry officials whose job it was to do precisely this."

Although by mid-2010 the president was not as personally involved as before the launch, free health care remained at the top of his agenda, and his administration still focused a substantial amount of time and energy to ensuring its success. The president's Strategy and Policy Unit, overhauled after the launch to improve on the delivery of the president's priorities, labeled free health care a "flagship priority," meaning that it received more attention than most other agenda items.

One by one, the committees stopped meeting after the launch, but challenges remained. Despite the health ministry's hiring 5,800 new workers, there were still only about 80 doctors on

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

the payroll at the time of the program's launch, and health facilities were still in need of highly trained staff. Furthermore, the government still had to improve the quality of care and put in place tougher monitoring and enforcement mechanisms to ensure health staff showed up for work and did not collect fees. In September 2011, a report by Amnesty International said that the quality of healthcare was "frequently substandard, and many women continue to pay for essential drugs despite the free care policy."[8]

In late 2011, questions continued to linger over the sustainability of the program. The Minister of Finance, Kamara, and his colleagues, with support from DFID and the World Bank, were studying how tax revenues from the extraction of the country's rich mineral and oil deposits could be used to help fund the initiative over the longer term. Yet for the foreseeable future, the government likely would rely on the donors to foot most of the bill.

REFLECTIONS

The success of the free health-care initiative hinged on getting the partners and structures in place to prioritize and coordinate efforts. But having a determined executive with a strong vision who exercised a leadership role throughout proved just as important in Sierra Leone.

"He was the authorizing sponsor," said Faye Melly of the Africa Governance Initiative, referring to Koroma. "The Ministry of Health did eventually show true leadership, but he was certainly there during times of troubleshooting and always acted as the figurehead."

Koroma's hands-on style of leadership impressed Mahimbo Mdoe of UNICEF. "When he would call these meetings with all of the key actors, he would actually stick to his schedule and not miss the meetings," Mdoe said.

Dr. Kisito Daoh, the chief medical officer, said that getting things done in a place like Sierra Leone required a significant investment in time and energy, something Koroma recognized early on. "You have to realize this is a long-term investment," Daoh said. "Otherwise, you will get easily disappointed, lose interest, and people around you will fail."

"We also have a very strong, committed team in the ministry," Daoh told an online newspaper in 2011.[9] "Free health care actually put everyone together in one boat with a very strong commitment, a very strong drive to succeed. And that keeps you going as chief medical officer."

Daoh pointed to the committee structure as a key element in addressing the government's capacity problem. "I would advise other countries trying something similar and faced with comparable obstacles in government to set up a committee structure so that there are regular meetings and people are aware of progress," Daoh said. He cautioned, however, that even with a rigorous reporting and information sharing system, simply holding meetings did not give leaders all of the facts they needed to make decisions. Leaders had to experience the projects first-hand, said Daoh. He cited Koroma's helicopter tour: "People, including the president, were not fully aware of the complexities of providing health care. But after his visits to the health centers, he realized it was much more complex than what had been written in the reports."

The complexities were not lost on those involved. "This was a hard win for the president," said Felton, DFID's former deputy head of office in Sierra Leone. "Reforming institutions is so much harder than building a new dam."

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

[1] CARE International, *Maternal Mortality: A Solvable Problem* (2010),
[2] Amnesty International, *Out of Reach: The Cost of Maternal Health In Sierra Leone* (2009), http://www.amnesty.org/en/library/asset/AFR51/005/2009/en/9ed4ed6f-557f-4256-989f-485733f9addf/afr510052009eng.pdf (9 January 2012).
[3] Government of Sierra Leone, *Free Healthcare Services for Pregnant and Lactating Women and Young Children in Sierra Leone,* (2009): 9.
[4] "Reducing Fees to Lower Child, Maternal Mortality Rates," *AllAfrica*, June 23, 2011 (http://allafrica.com/stories/201106240047.html).
[5] AllAfrica, June 23, 2011.
[6] "Sierra Leone Doctors and Nurses Get Massive Pay Rise," *BBC News*, March 28, 2010 (http://news.bbc.co.uk/2/hi/8591682.stm).
[7] Sierra Leone Ministry of Health and Sanitation, *Free Health Care Initiative,* (2010): 6.
[8] Amnesty International, *At a Crossroads: Sierra Leone's Free Health Care Policy* (2011), http://www.amnesty.org/en/library/asset/AFR51/001/2011/en/4de27bf1-aebb-4944-8005-1458b4c44edb/afr510012011en.pdf (9 January 2012).
[9] "Reducing Fees to Lower Child, Maternal Mortality Rates," *AllAfrica*, June 23, 2011 (http://allafrica.com/stories/201106240047.html).

© 2012, Trustees of Princeton University
Terms of use and citation format appear at the end of this document and at www.princeton.edu/successfulsocieties

Innovations for Successful Societies makes its case studies and other publications available to all at no cost, under the guidelines of the Terms of Use listed below. The ISS Web repository is intended to serve as an idea bank, enabling practitioners and scholars to evaluate the pros and cons of different reform strategies and weigh the effects of context. ISS welcomes readers' feedback, including suggestions of additional topics and questions to be considered, corrections, and how case studies are being used: iss@princeton.edu.

Terms of Use

In downloading or otherwise employing this information, users indicate that:

a. They understand that the materials downloaded from the website are protected under United States Copyright Law (Title 17, United States Code). This work is licensed under the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License. To view a copy of this license, visit http://creativecommons.org/licenses/by-nc-nd/4.0/.
b. They will use the material only for educational, scholarly, and other noncommercial purposes.
c. They will not sell, transfer, assign, license, lease, or otherwise convey any portion of this information to any third party. Republication or display on a third party's website requires the express written permission of the Princeton University Innovations for Successful Societies program or the Princeton University Library.
d. They understand that the quotes used in the case study reflect the interviewees' personal points of view. Although all efforts have been made to ensure the accuracy of the information collected, Princeton University does not warrant the accuracy, completeness, timeliness, or other characteristics of any material available online.
e. They acknowledge that the content and/or format of the archive and the site may be revised, updated or otherwise modified from time to time.
f. They accept that access to and use of the archive are at their own risk. They shall not hold Princeton University liable for any loss or damages resulting from the use of information in the archive. Princeton University assumes no liability for any errors or omissions with respect to the functioning of the archive.
g. In all publications, presentations or other communications that incorporate or otherwise rely on information from this archive, they will acknowledge that such information was obtained through the Innovations for Successful Societies website. Our status (and that of any identified contributors) as the authors of material must always be acknowledged and a full credit given as follows:

   Author(s) or Editor(s) if listed, Full title, Year of publication, Innovations for Successful Societies, Princeton University, http://successfulsocieties.princeton.edu/

© 2019, Trustees of Princeton University