



NATIONAL HEALTH SECTOR STRATEGIC PLAN 2017 – 2021

Ministry of Health and Sanitation
September 2017

FOREWORD

I am pleased to present Sierra Leone's new National Health Sector Strategic Plan, 2017 – 2021. This document is the culmination of the unprecedented levels of activity, investment and partnership that have characterized Sierra Leone's health sector over the past several years.

Sierra Leone has faced many trials, big and small, since declaring our independence 56 years ago. The most significant of these was Sierra Leone's civil war, which lasted more than a decade until its end in 2002 and exacted a terrible toll on our young nation. After ten years of conflict, Sierra Leone's health sector was deeply damaged, and our ability to provide health services severely curtailed. However, with fresh focus and commitment by the leadership of the Government of Sierra Leone (GoSL) – including the advent of the Free Healthcare Initiative in 2010 – the professionals of the Ministry of Health and Sanitation (MoHS) began to put the country once again on the path to health and wellness, making significant strides in reducing maternal and child mortality. Our goal, as it has always been, is to help all Sierra Leoneans lead healthier, happier and more productive lives.

However, everything changed once again in 2014, when the MoHS began to receive reports of a strange illness that was rapidly spreading throughout our country. This, of course, was the Ebola Virus Disease (EVD), which would go on to ravage communities across Sierra Leone and ultimately sicken more than 10,000 Sierra Leoneans. EVD also robbed the MoHS of nearly 300 of our best and brightest doctors and nurses, who fulfilled their duties to their patients – but at the cost of their own lives. Despite this terrible cost, the GoSL rose to the challenge once more. Working with our communities and our partners, we were able to declare Sierra Leone Ebola free once again in November of 2015.

Our attention then turned to the daunting task of recovery – not just of the health sector, but the entire country. The President laid forth his Presidential Recovery Priorities, and staff at the MoHS worked tirelessly to develop a new Basic Package of Essential Health Services (2015 – 2020) and a new National Health Sector Recovery Plan (2015 - 2020). Our goal was once again clear – to put the health sector back to work, and resume and accelerate our progress towards better health outcomes for all Sierra Leoneans – especially our expectant and new mothers, and their young children.

Something else happened as a result of these efforts. With all of the new resources and attention that EVD brought to Sierra Leone, we were able to begin to develop and execute additional plans across the sector, for all of the many focus areas that the MoHS is responsible for – from HIV; to reproductive, maternal, neonatal and child health; to nutrition; and in a great number of other topics as well. A tremendous amount of work has been done, with no less than 20 new strategies and policies either in development or recently launched, that will improve the functioning of our health sector.

This new NHSSP attempts to synthesize and summarize all of this important work, articulating a clear vision for the next five years while fitting seamlessly into all of the work that has already been done. To that end, the following document is structured around the core Health Systems Strengthening (HSS) pillars, namely 1) Leadership and Governance, 2) Service Delivery, 3) Human Resources for Health, 4) Medical Products and Technologies, 5) Information Systems and 6) Health Financing. Since Sierra Leone's health sector is unique – only Liberia and Guinea have been through the same struggles with EVD – we have also added 7) Health Security and Emergencies, and 8) Community Engagement and Health Promotion.

Given the tremendous complexity and level of activity in the health sector, I hope you find the following document a clear and digestible representation of our ongoing plans. I also want to thank the Directorate of Policy, Planning and Information for taking the lead on developing this document; the staff of the MoHS – both our central and district teams – for contributing; and our partners for supporting us with the resources required to develop documents like this.

In closing, let me say this. I believe that good healthcare is a right that all Sierra Leoneans should be able to count on, whether they are born in Kabala, Kenema or Kroo Bay. And for too long, Sierra Leoneans have struggled to access quality care. The promise of health as a human right in our country has not yet been fulfilled. But it is my sincere hope that the MoHS can change that, in close partnership with the leadership at State House, our compatriots across the GoSL and the development organizations who share our mission and drive to improve healthcare in Sierra Leone.

As the Minister of Health and Sanitation, it is my mission to make sure that dream becomes a reality.

Hon. Dr. Abu Bakarr Fofanah
Minister of Health and Sanitation
September 2017

REMARKS

The Sierra Leone National Health Sector Strategic Plan 2017-2021 (HSSP II) comes at a critical time for the country: it marks Sierra Leone's recovery from the Ebola Virus Disease outbreak while ushering in a new era of Sustainable Development Goals (SDGs). It also builds on the tremendous efforts of all the government and partner stakeholders in developing programme-specific and sub-sector strategies over the past two years. These plans form the foundation for better health security, preventing deaths, tackling diseases, strengthening the health system and improving the health and well-being of the population. The HSSP II provides the overall direction for the sector, prioritizing and orienting efforts around the most pressing issues that need to be addressed. It also provides a basis for longer-term practices that are vital for the country's achievement of the SDGs.

The HSSP II was developed under the leadership of the Director, Policy, Planning & Information Directorate through a participatory process. Successive rounds of consultations with stakeholders from the ministries, departments and agencies of the Government of Sierra Leone, development partners, civil society, non-governmental organizations, faith-based institutions, district health management teams, district councils, hospitals, training institutions and, for the first time in the country, in-charges from over 900 health facilities, has yielded a robust plan which reflects the voices, needs and expectations of the population. I would like to acknowledge the tremendous effort made by all stakeholders in engaging around such an inclusive process to develop a comprehensive plan. I am also grateful to the technical and financial support provided by our partners, in particular the World Health Organization and the European Union, for the development of the HSSP II.

There is still much to do – the future of the country's health depends on the successful implementation HSSP II and requires a concerted efforts at all levels; national, district, facility and community; and by all stakeholders – I look forward to our collective work ahead.

Dr. Brima Kargbo (GOOR)
Chief Medical Officer
Ministry of Health and Sanitation

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ACRONYMS

Central Government

GoSL	Government of Sierra Leone
MEST	Ministry of Education Science and Technology
MoFED	Ministry of Finance and Economic Development
MoHS	Ministry of Health and Sanitation
MoIA	Ministry of Internal Affairs
MoLGRD	Ministry of Local Government and Rural Development

Ministry Leadership, Directorates and Programs

CMO	Chief Medical Officer
PS	Permanent Secretary

MoHS Directorates and Programs

DDMS	Directorate of Drugs and Medical Supplies
DHLS	Directorate of Hospitals and Laboratory Services
DHRH	Directorate of Human Resources for Health
DPHC	Directorate of Primary Healthcare
DPPI	Directorate of Policy, Planning and Information
DRCH	Directorate of Reproductive and Child Health
DSS	Directorate of Support Services
PDT	Presidential Delivery Team

Ministry Agencies

HSC	Health Services Commission
NEMS	National Emergency Services
NMSA	National Medical Supplies Agency
NPHA	National Public Health Agency
NPPU	National Pharmaceutical Procurement Unit
SLESHI	Sierra Leone Social Health Insurance

District Government

DHMTs	District Health Management Team
DMO	District Medical Officer
DMS	District Medical Stores

Key Donors and Bilaterals

DFID	UK Department for International Development
EU	European Union
Gavi	Global Alliance for Vaccines and Immunization

GFATM	Global Fund to Fight AIDS, TB and Malaria
GIZ	German Development Corporation
Irish Aid	--
JICA	Japanese International Cooperation Agency
KfW	Kreditanstalt für Wiederaufbau /German Development Bank
USAID	US Agency for International Development
WB	World Bank

UN Agencies

UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

Overarching Documents/Commitments

A4P	Agenda for Prosperity
BPEHS	Basic Package of Essential Health Services
MDGs	Millennium Development Goals
NHSSP	National Health Sector Strategic Plan
SDGs	Sustainable Development Goals

Health System Terminology

AMR	Antimicrobial Resistance
ANC	Antenatal Care
ART	Antiretroviral Therapy
BEMONC	Basic Emergency Obstetric and Neonatal Care
CEMONC	Comprehensive Emergency Obstetric and Neonatal Care
CHC	Community Health Center
CHP	Community Health Post
CHW	Community Health Workers
DHIS	District Health Information System
DHS	Demographic and Health Survey
FHC	Free Healthcare Initiative
FMC	Facility Management Committee
HRH	Human Resources for Health
HRIS	Human Resource Information System
IMR	Infant Mortality Rate
KPI	Key Performance Indicator
LMIS	Logistics Management Information System
MCHP	Maternal and Child Health Post
MMR	Maternal Mortality Rate
NMR	Neonatal Mortality Rate
PHU	Peripheral Health Unit
PLHIV	People Living with HIV

PSM	Procurement and Supply Chain Management
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SARA	Service Availability and Readiness Assessment
U5MR	Under-Five Mortality Rate
VDC	Village Development Committee

EXECUTIVE SUMMARY

Today, Sierra Leone is at a crossroads. Following a decade-year long civil war, which ended in 2002, the government and people of Sierra Leone faced a terrifying disaster when the Ebola epidemic arrived in 2014. The epidemic would go on to become the largest Ebola epidemic ever recorded. However, through the courage of the Sierra Leonean people, their Liberian and Guinean neighbors, and their international partners, the epidemic was stopped and Sierra Leone declared Ebola-free in November 2015. The Ebola epidemic and its aftermath brought a significant new level of focus and resources, both international and domestic, to country's health sector.

Sierra Leone has a reputation for resilience for good reason. The country's leaders and its citizens have been developing its economy, government and civil society during the decade between the civil war and the beginning of the Ebola epidemic. For the health sector, this culminated in the promise of the Free Healthcare Initiative – launched in 2010 – which would deliver free care to all pregnant and lactating women, children under five, and other select at-risk groups. In particular, many key output and coverage indicators have improved in recent years. Although the country still has some of the worst health indicators in the world – in particular on maternal and child mortality – there is a keen interest in leveraging the resources and experience of the Ebola epidemic to make significant strides forward in the health sector.

The implementation of the previous National Health Sector Strategic Plan I (HSSP) 2010-2015 was hindered by the Ebola outbreak. However, a Health Sector Recovery Plan 2015-2020, of which the President's Recovery Priorities was a key component, served to focus attention and investments on the most pressing issues facing the sector. Building on these efforts, several sub-sector and programmatic plans were developed and are currently being implemented by the MoHS and partners.

HSSP 2017 – 2021

The MoHS' **vision** for the health sector sets forth a long-term direction for the health space, building on the promise of the SDGs: *A well-functioning national health system that delivers efficient and high-quality healthcare and ultimately contributes to the socioeconomic development of the country. This care must be of high quality, accessible, affordable and equitable to all Sierra Leoneans.*

The **mission** is: *To address and resolve – in a serious, credible and evidence-based manner – the significant health systems challenges that must be solved in order to achieve the MoHS' vision. This will require improved coordination of plans, activities and resources among GoSL and its partners.*

Leveraging the tremendous work undertaken over the past few years, the HSSP II 2017 – 2021, covers **eight pillars**:

1. Leadership and governance
2. Service delivery
3. Human resources for health
4. Health financing
5. Medical products and health technologies
6. Health information systems and research
7. Health security and emergencies
8. Community engagement and health promotion

Implementation of HSSP II

Implementation of the HSSP II will be done in a phased manner, which will include establishing a framework through which the MoHS and partners can manage the plan. The MoHS will work closely with the DHMTs and district hospitals to develop annual operational plans, which will serve as the basis for identifying detailed needs at the sub-national levels, along with corresponding budgets and indicators.

Monitoring and evaluation of HSSP II

MoHS will track progress towards the key targets identified for making progress in the sector, taking into account the monitoring, supportive supervision and information needs for the HSSP II. Periodic sector reviews (mid-year and annual), will bring together all the key government stakeholders and partners to track progress, identify gaps and take remedial actions to address salient challenges that serve as a barrier to the successful implementation of the HSSP II. A final evaluation of the HSSP II will be conducted to assess the overall impact of the investments and the health gains achieved over the implementation period

Cost of HSSP II

Since the HSSP leverages many sub-sector plans that have been developed in recent years, many of which are already funded, in full or in part, the MoHS did not want to introduce yet another sector budget that would serve only to confuse. It is anticipated that a new Health Financing strategy is able to collate and develop a rigorous sector-wide budget, resource map, and processes to better manage the flow of funds. In the interim, estimates from the sub-sector plans provide a sense of resources that the sector will require over the coming years if the MoHS and partners want to ensure a significant impact on health indicators in Sierra Leone.

SECTION I: COUNTRY BACKGROUND

A. Geography, Demography and Governance

Sierra Leone is a small West African country of approximately 7 million people¹, bordered by Guinea, Liberia and the Atlantic Ocean. It recently celebrated its 56th year of independence, which the country gained from Great Britain in 1961 under the guidance of Sir Milton Margai, the country's first Prime Minister. Today, Sierra Leone is a constitutional republic, governed by an elected president as well as a single house of Parliament. The current President is Ernest Bai Koroma, who was elected in 2007 and re-elected to a second-term in 2012. Presidential and parliamentary elections are both planned for 2018.

The country is subdivided into four administrative regions – the North, East and Southern provinces, as well as the Western Area, where the capital city of Freetown is located. Roughly 21% of Sierra Leoneans live in the geographically small Western Area; 35% in the North; 23% in the East; and 20% in the South.² These regions are further subdivided into 14 districts. Freetown, the capital, is located in Western Area. The districts are further subdivided into 152 chiefdoms. The Government of Sierra Leone (GoSL) has been attempting to devolve many functions to the district and chiefdom levels since the Local Government Act was passed in 2004, with mixed results across its various sectors. The country has roughly fifteen different ethnic groups.³ The official language is English, and most individuals also speak Krio, the most common local language.

Figure 1: Map of Sierra Leone



¹ Statistics Sierra Leone, 2015 Population and Housing Census Summary of Final Results, 2016, https://www.statistics.sl/wp-content/uploads/2017/01/final-results_-2015_population_and_housing_census.pdf

² Ibid

³ Statistics Sierra Leone, Sierra Leone Demographic and Health Survey 2013, 2014, <https://dhsprogram.com/pubs/pdf/FR297/FR297.pdf>

B. Economics, Human Development and Humanitarian Crises

Sierra Leone was thrown into chaos during its decade-year long civil war, which began in 1991 and was ended only in 2002. Tens of thousands of Sierra Leoneans were killed during this period, while the war also destroyed the infrastructure and systems on which any government relies. The after-effects of the conflict can still be felt today. Roughly 52%⁴ of Sierra Leoneans live below the poverty line, and life expectancy for an average Sierra Leonean citizen is 50 years of age.⁵

Nevertheless, Sierra Leone has a reputation for resilience for good reason. The country's leaders and its citizens began to develop its economy, government and civil society once more during the decade between the civil war and the beginning of the Ebola epidemic. For the health sector, this culminated in the promise of the Free Healthcare Initiative – launched in 2010 – which would deliver free care to all pregnant and lactating women, children under five, and other select at-risk groups.

However, once again, the government and people of Sierra Leone faced a terrifying disaster. The Ebola epidemic arrived in Sierra Leone in 2014, after crossing the border from rural Guinea. The epidemic would go on to become the largest Ebola epidemic ever recorded, and one that would paralyze much of West Africa during 2014 and 2015. However, through the courage of the Sierra Leonean people, their Liberian and Guinean neighbors, and their international partners, the epidemic was stopped and Sierra Leone declared Ebola-free in November 2015.

Even so, the epidemic did tremendous damage to the country. Between deaths that were directly a result of the Ebola virus – and others that were caused as a result of Sierra Leoneans not accessing care during the epidemic – Sierra Leone suffered yet another crushing loss of life, with more than 14,000 total cases and nearly 4,000 deaths.⁶ Conservative estimates suggest that as many as another 2,819 individuals perished from malaria, HIV/AIDS, and tuberculosis alone due to the lack of accessible medical care for other issues during the time of the epidemic.⁷

Today, Sierra Leone is at a crossroads. The Government of Sierra Leone – and the Ministry of Health and Sanitation in particular – has the difficult task of trying to get Sierra Leone's health sector back on track. The country still has some of the worst health indicators in the world – in particular on maternal and child mortality – but a keen interest in leveraging the resources and experience of the Ebola epidemic to make significant strides forward in the health sector.

C. Sierra Leone, the Sustainable Development Goals and other global/regional commitments

The 2030 Sustainable Development Agenda has the potential to play a key role at this pivotal moment in the trajectory of Sierra Leone's health sector and overall development. The Sustainable Development Goals (SDGs) comprise a broad range of objectives that integrate several dimensions of sustainable development around people, planet, prosperity, peace, and partnership (WHO, 2015). Sustainable Development Goal Three (SDG 3) seeks to *ensure healthy lives and promote wellbeing for all at all ages*.

⁴ The World Bank, World Development Indicators, 2011, <http://databank.worldbank.org/data/home.aspx>.

⁵ World Health Organization, Global Health Observatory, 2015, <http://apps.who.int/gho/data/node.cco>

⁶ Centres for Disease Control and Prevention, "2014 Ebola Outbreak in West Africa – Case Counts," 2016, <https://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html>

⁷ Alyssa S. Parpia, Martial L. Ndeffo-Mbah, Natasha S. Wenzel, and Alison P. Galvani, "Effects of Response to 2014–2015 Ebola Outbreak on Deaths from Malaria, HIV/AIDS, and Tuberculosis, West Africa," *Emerging Infectious Diseases* 22, no. 3 (2016): 433-441. <http://doi.org/10.3201/eid2203.150977>.

Prior to the introduction of the SDGs, Sierra Leone demonstrated its commitment to achieving progress towards targets outlined in the Millennium Development Goals (MDGs). The United Nation's summary report of adaptation of the goals reported that the poverty headcount has declined from 70% to 53% from 2003 through 2013, access to safe drinking water increased from 37% in 1990, to 63% in 2015, and the ratio of girls to boys in primary school was close to 100% (United Nations, Sustainable Knowledge Platform). However, the shock of economic and health crises that struck the country towards the end of the MDG timeline undermined and, in some cases, reversed progress made towards achievement of MDGs.

As Sierra Leone continues to recover and return to pre-Ebola health system priorities, there is a renewed call for long-term, sustainable, and equitable progress towards achieving universal health coverage (UHC) and improving health for all Sierra Leoneans. The government of Sierra Leone can harness the focus and intent of the SDGs to deliver on this promise. The SDGs recognize the importance of partnerships within and across sectors, as well as the crucial priority of focusing on systems to improve health and wellbeing. Especially within the context of a low-income country like Sierra Leone, increased recognition of the importance of synergies across other sectors and a commitment to health systems strengthening and capacity building will be critical to the achievement of meaningful change. These principles are reflected in the objectives and activities found in this document.

Specifically for the SDG 3, the Government of Sierra Leone, and in particular the MoHS, has been working actively to develop interventions aimed at achieving the adapted targets. This has entailed ensuing that programmatic and sub-sector strategies such as the RMNCAH strategy and Human Resources for Health (HRH) strategic plan take into account the required investments and resources to reach SDG 3 targets by 2030. Additionally, determinants of health, which are covered under other SDGs (such as education, water, food security) will have an impact on policies in the health sector and beyond. Considering that the under-five mortality and maternal mortality will decrease, it will be even more important to ensure that people not only survive but live long and healthy lives. The complete list of SDG 3 targets for the country can be found in Annex 4.

In addition to the Sustainable Development Goals being a main driver for the sector in the coming years, Sierra Leone is also a key partner in the UHC2030 (formerly known as the International Health Partnership IHP+). The country's active engagement in this initiative speaks to the government's commitment to strengthening the country's health system towards universal health coverage.

Furthermore, Sierra Leone is signatory of the Abuja Declaration, pledging to set a target of allocating at least 15% of its annual budget to improving the health sector, while also committing to several other global requirements such as the International Health Regulations and the Framework Convention on Tobacco Control and regional initiatives such as the Ouagadougou Declaration on Primary Healthcare and Health Systems.

D. Sierra Leone Burden of Disease

This section provides a general overview of Sierra Leone's health indicators, and trends over time. Further information on specific disease burdens can be found in the Service Delivery chapter, while further information on relative causes of morbidity and mortality as well as cross-country indicator comparisons can be found in the Annexes. In short, despite significant investment over the past several decades, Sierra Leone retains some of the worst health indicators in the world – and improvements in

health indicators have also been punctuated by slowdowns or reversals during the civil war and the Ebola epidemic. Life expectancy remains low, while Sierra Leone’s maternal, under-five and neonatal mortality ratios all remain on the high end compared to other countries across the region.

While key outcome indicators have not dramatically improved in recent years, Sierra Leone’s health sector has still made progress since the launch of the last HSSP in 2010. In particular, many key output and coverage indicators that are collected through both the Demographic and Health Survey (DHS) (2008 and 2013) and the Multiple Indicator Cluster Survey (MICS) (2000, 2005 and 2010) – both large household survey exercises – have improved in recent years. There has not yet been a similar exercise that provides a full accounting of the status of the health sector post-Ebola, though another MICS will be completed in 2017 and another DHS is planned for 2018.

Sierra Leone’s RMNCAH landscape provides an instructive example of this trend. Sierra Leone does not appear to have seen significant gains in terms of certain outcomes, with the maternal, infant and neonatal mortality ratios all staying roughly the same or rising between the 2008 and 2013 DHS surveys. (The MICS 2010 suggests even higher numbers). There has been more significant improvement on the under-five mortality rate. At the same time, Sierra Leone has seen some significant gains in the provision of certain health services, with a number of coverage and output indicators demonstrating significant improvements between the 2008 and 2013 DHS (e.g., ANC visits). This suggests that a focus on improving the *quality* of services should be a clear priority within this five-year plan.

The table below demonstrates these gains across the DHS 2008 and DHS 2013.

Table 1: Selection of DHS Indicators – Changes over Time

Indicators	DHS 2008	DHS 2013
IMPACT INDICATORS		
Infant mortality rate (per 1,000 live births)	89 /1,000	92/1000
Under-five mortality rate (per 1,000 live births)	140 /1,000	156 / 1000
Maternal mortality ratio (per 100,000 live births)	857 /100.000	1,165 /100,000
Prevalence of HIV (% of pop. aged 15–49)	1.50%	1.5%
Total Fertility Rate	5.1	4.9
OUTCOME / OUTPUT INDICATORS: RMNCAH		
% Births attended by skilled staff (Public and Private)	42%	54% MCHA 14%, Nurse 44%
% Pregnant Women making 4 antenatal visits	> 50	76
Contraceptive prevalence rate (% of women 15–49)	14%	16%
Unmet need among married women for family planning	28%	25%
% Children < 1 yr fully vaccinated	40	58
OUTCOME / OUTPUT INDICATORS: Nutrition		
Prevalence of Underweight (Wt/Age) among children 6-59 months (2SD)	21%	16%
Prevalence of Stunting (Ht/Age) among children 6-59 months (2SD)	36%	38%
Prevalence of Wasting (Ht/Wt) among children 6-59 months (2SD)	10%	9%
OUTCOME / OUTPUT INDICATORS: Communicable Diseases		
# Health facilities with VCT / PMTCT / ARV	398 / 351 / 111	708 / 691 / 136
% children sleeping under LLITN night before	26%	49%
TB Case Detection Rate	NA	38
TB Treatment success rate	NA	87

SECTION II: HSSP II 2017-2021 DEVELOPMENT PROCESS

The successive drafts of the HSSP – culminating in this final version – were developed in consultation with various MoHS and partner stakeholders in the Sierra Leonean health sector. The Directorate of Policy, Planning and Information (DPPI) was the lead stakeholder on the MoHS side, with partner support primarily coming from the World Health Organization (WHO). Consulted parties throughout this process included MoHS stakeholders at the central, district health management teams (DHMTs) and facility level; representatives from other key line Ministries; health development partners; NGOs; technical assistance providers; district and community level stakeholders who were able to attend the regional consultations; and many others.

Given the significant amount of policy and strategy work that the MoHS and partners have conducted in the health sector since the end of Ebola, the first step in developing this document was a full mapping of existing materials that are currently driving activities within the MoHS. Once this groundwork was collected, a series of national-level meetings occurred to brief stakeholders on the process. Presentations were made during Q2 and Q3 2017 at the Health Development Partners meeting; at the Health Sector Steering Group meeting; at a World Bank workshop on the health sector; and at a special session of MoHS directors and senior staff.

Additionally, the DPPI also conducted a rapid survey of in-charges in over 940 health facilities, which provided a critical perspective from those on the frontline of delivering health services in the country.

Inputs from these meetings were collated and incorporated into a draft for circulation and consultation, which was shared nationally with a wide variety of stakeholders. The circulation of this draft was followed up by a series of regional consultations in July 2017 – with Western area stakeholders in Freetown; in the South and East in Bo; and in the North in Makeni. Inputs from these consultations were used to further refine the draft document. In August 2017, the final draft was circulated for feedback from all interested parties before its launch in September 2017.

SECTION III: LOOKING BACK, LOOKING FORWARD

A. Achievements and Challenges of HSSP I: 2010 – 2015

In late 2015, the MoHS Directorate of Policy, Planning and Information worked with the World Health Organization (WHO) to assemble a team that would review the 2010-2015 National Health Sector Strategic Plan. The team, comprising three international consultants and two national MoHS staff members, examined progress across each of the six core HSS pillars over the course of two weeks, delivering a final report on health sector progress against the 2010-2015 HSSP in February of 2016. Although two weeks is a short amount of time in which to conduct such a broad review, and the review activities only included limited field visits, the findings are nevertheless helpful and instructive when considering the form and function of the next HSSP 2017-2021.

Overall, the authors found that Sierra Leone's health sector was on track before the Ebola epidemic, and in particular was putting in place the right plans, policies and frameworks – such as the HSSP itself, the BPEHS, and the launch of the FHC Initiative – that would help improve health services in Sierra Leone. As noted above, while Sierra Leone has not seen any marked achievements in regards to its impact indicators, the health sector did achieve some of its targets on an output level by the time of the 2013 DHS – only 3 years into the HSSP I – such as increasing ANC visits, births attended by skilled staff and contraceptive prevalence. Whether Sierra Leone might have achieved significantly greater gains in both outcomes and outputs will forever remain unknown; EVD removed that possibility.

The review team also highlighted a number of key challenges regarding the HSSP I period, including but not limited to: an underfunded health sector, along with inefficient resource use and value for money (VFM); an overabundance of health facilities, coupled with financial and cultural reasons for not accessing care. The basic functioning of the government also represents a significant challenge, and in particular the confused and inefficient implementation of health sector decentralization, along with poor health financing practices stretching across MOFED and MOHS. This document will not present any detailed findings from the review; however, specific challenges identified by the review team as well as some of their key recommendations will appear throughout the remainder of this document.

B. Recovering from Ebola – and a Proliferation of Health Sector Strategies: 2015 – 2017

The Ebola epidemic and its aftermath brought a significant new level of focus and resources, both international and domestic, to Sierra Leone's struggling health sector. In early 2015, as the Ebola epidemic was brought under control, the MoHS tried to ensure that a basic plan and framework for the recovery of the health sector were quickly put into place. This was complemented by multi-sectoral efforts led by State House to also ensure there was a broader recovery plan for the country as a whole that could put Sierra Leone back on the pathway of its country-wide *Agenda for Prosperity: Road to Middle Income Status by 2035 (A4P)*, which runs from 2013 to 2018. Three critical documents and plans were launched in early to mid-2015 in line with these early health sector recovery efforts.

- **Basic Package of Essential Health Services (2015 – 2020):** The original version of the BEPHS was developed in 2010 as a guide to how and where health services should be delivered in the public sector in Sierra Leone; the 2015 version was revised to be significantly more ambitious, although

the HSSP I review team noted that it does not make health services more affordable or efficient as written. Realistically, only a miniscule portion of the services described in the new document can be provided at the levels of care described in the document. Nonetheless, it formed the backbone for the MoHS' new health sector vision.

- **National Health Sector Recovery Plan (2015 – 2020):** The recovery plan, developed through a series of consultative meetings in early 2015, lays out a basic framework to put the health sector back to rights. This HSSP draws heavily on certain key elements of the plan, in line with the HSSP I review team's recommendation.
- **President's Recovery Priorities (2015 – 2017):** Led by State House with the participation and drive of the GOSL's various line Ministries, the PRP was first put into place as the '6-9 Month Recovery Plan' in March 2015, and has since been revised to stretch across a full 2-year period.

These three documents have shaped the early trajectory of Sierra Leone's recovery from Ebola. In addition, due to a combination of factors – including the significant level of new resources brought to the health sector in the aftermath of Ebola; the expiry of some existing sub-sector plans; and a lack of coordination within the MoHS and among donors as to the framework of specific plans that might be needed – there has been a proliferation of new plans, policies, and strategies developed and launched since mid-2015. At the time of writing this document, the drafting team has counted no less than 20 documents launched between mid-2015 and mid-2017, amounting to more than 1,800 pages.

The development of all of these additional documents has been a mixed blessing for Sierra Leone's health sector. On the one hand, the resources made available in the wake of Ebola have brought new and heretofore unseen attention and energy to areas such as human resources for health (HRH), medical products and information systems – all of which occupy their own sections in this plan. On the other hand, as the health sector has become more diverse, it has also become more fragmented. MoHS staff and resources have not grown in direct proportion to the many new areas of planned activity, and as such the implementation of all of the many sub-sector plans, policies and other documents appears an insurmountable task.

Figure 2: Overview of Plans and Policies

Description	Type	Timeline						
		2015	2016	2017	2018	2019	2020	2021
<i>HIV/AIDS</i>	Strategy		<				>	
<i>TB & Leprosy</i>	Strategy		<				>	
<i>Malaria</i>	Strategy		<				>	
<i>Insecticide Resistance</i>	Strategy			<			>	
<i>RMNCAH</i>	Strategy			<				>
<i>Family Planning <-- under development</i>	CIP							
<i>Vaccines</i>	Strategy			<				>
<i>Nutrition</i>	Strategy			>				
<i>Anemia <-- under development</i>	Strategy							
<i>Mental Health</i>	Policy							
<i>NTDs</i>	Strategy		<				>	
<i>HRH</i>	Strategy			<				>
<i>HRH</i>	Policy							

<i>CHWs</i> <-- under development	Strategy			
<i>CHWs</i>	Policy		<	>
<i>Supply Chain</i>	Strategy		<	>
<i>Labs</i>	Strategy		<	>
<i>HIS</i>	Strategy		<	>
<i>Health Financing</i> <-- under development	Strategy		<	>
<i>Public Health Agency</i> <-- under dev.	Strategy			
<i>Health Promotion</i>	Strategy			
<i>AMR</i> <-- under development	Strategy			
<i>IPC</i>	Plan		<	>
<i>IPC</i>	Policy	-		
<i>Environmental Health</i>	Strategy	<		>
<i>Waste Management</i>	Strategy		>	
<i>Pest Management</i>	Strategy		<	>
<i>Pesticides Management</i>	Policy		-	

C. Purpose of HSSP II: 2017 - 2021

It is in this context that the Directorate of Policy, Planning and Information (DPPI) came to understand that a new HSSP could serve as a useful way of organizing a tremendous outpouring of energy and resources in different areas across the sector into one coherent, prioritized, and efficient plan that would drive coordination in the health sector take the MoHS through the next five years – as the President’s Recovery Priorities come to an end, and the health sector shifts from recovery back towards a more stable and functional environment.

Using this moment to pivot to a new footing will also help the MoHS begin to think longer-term about its goals and objectives. The development of this document has been executed in tandem with a refresh of the National Health Policy, which will articulate a proactive vision for the MoHS in relation to a set of longer-term goals for the health sector, including the Sustainable Development Goal for health as well as the long-term promise of universal health coverage. Given all of the significant work that has already been done by the MoHS’ directorates, programmes, units and agencies relative to the sub-sector plans described above, this current effort will not attempt to replicate or replace any of the good work that has already been done. Rather, the remainder of this document will aim to organize, summarize and prioritize the tremendous amount of work that has occurred to date.

D. HSSP II: 2017-2021 – Mission and Vision

The MoHS' **vision** for the health sector sets forth a long-term direction for the health space, building on the promise of the SDGs.

Vision: A well-functioning national health system that delivers efficient and high-quality healthcare and ultimately contributes to the socioeconomic development of the country. This care must be of high quality, accessible, affordable and equitable to all Sierra Leoneans.

The MoHS' **mission** for the health sector – the pathway it must follow to achieve its vision – sets forth a medium-term challenge, to all health sector stakeholders, to mount an energetic new campaign of policy-making and program implementation that will address the most systemic and fundamental issues in the health sector that prevent meaningful forward progress.

Mission: To address and resolve – in a *serious, credible and evidence-based* manner – the significant health systems challenges that must be solved in order to achieve the MoHS' vision. This will require improved coordination of *plans, activities and resources* among GoSL and its partners.

E. Assumptions and Risks

The vision and mission described above – as well as the visions and missions described for each of the existing sub-sector plans below – are only achievable if the following assumptions are shown to be a political, financial and operational reality by the GoSL and its partners:

- **Politics:** The political class must ensure that health remains one of the GoSL's top priorities, and redouble their efforts to provide a secure political environment where health remains – consistently – a focused priority year on year.
- **Governance:** The MoHS must continue to make improvements to its structure and function in order to more effectively deliver on its mandate.
- **Finances - GoSL:** The budgetary allocation for health within GoSL must increase year on year over the next five years, and the GoSL must meet their Abuja declaration commitment of 15% of GDP spent on the health sector.
- **Finances – Health development partners:** GoSL commitments will not be sufficient to execute this plan; development partners must maintain – and in some cases increase – their commitments to the sector. More support needs to be channeled through Government budgets, in order to increase sustainability and system strengthening.
- **Financial Accountability and Transparency:** All finances for health – held by both GoSL and development partners – must be managed with regards to the efficiency, effectiveness and value for money at every stage of the budgeting and expenditure and reporting process.
- **Legal Frameworks:** The statutory framework by which the health sector is governed must continue to be expanded, revised and improved.

SECTION IV: SIERRA LEONE HEALTH SYSTEM PILLARS

CHAPTER 1: LEADERSHIP AND GOVERNANCE

This section provides an overview of the leadership and governance challenges facing the MoHS today, along with key strategies to improve the management of the health sector. This includes activities to enhance the statutory frameworks on which the health sector operations; the structure and function of the MoHS itself, at the central and subnational level; the coordination of stakeholders; the methods by which planning, policy and prioritization occur in the sector; and the routine evaluation of MoHS performance. There are no specific plans that correspond directly to leadership and governance matters in the sector, although may sub-sector plans reference this topic and the associated challenges described below.

A. Legislation

Current Status and Situation Analysis

In recent years, Sierra Leone’s Parliament has passed a number of Acts that are related to the governance of the health sector. In addition, the MoHS with its partners are working on a number of pieces of legislation that will strengthen the national health system and ensure that the rights of those in need are met. However, the principal piece of health-related legislation in Sierra Leone – the *Public Health Ordinance Act, 1960* – is quite dated and in need of revision; and additional gaps also exist in other areas of Sierra Leone’s legislative frameworks for health, which are outlined in the table below:

Figure 3: Sierra Leone’s Legal Framework for Health

	Existing health-related legislation	Planned revisions or new Acts
General Sector Governance⁸	<ul style="list-style-type: none"> Public Health Ordinance Act 1960 Local Government Act, 2004 Finance Bill, 2017 (FHC Tax) 	<ul style="list-style-type: none"> Public Health Act(<i>revision</i>)
Health Issues	<ul style="list-style-type: none"> Lunacy Act, 1902 The Prevention and Control of HIV and AIDS Act, 2007 The National HIV and AIDS Commission Act, 2011 	<ul style="list-style-type: none"> Mental Health Act(<i>revision</i>) The Safe Abortion Act, 2015 (<i>under review</i>)
Health Agencies or Bodies (Non-regulatory)	<ul style="list-style-type: none"> Hospital Boards Act, 2003 Sierra Leone Health Services Commission Act, 2011 National Pharmaceutical Procurement Act, 2012 Sierra Leone Council for Postgraduate Colleges of Health Specialties Act, 2016 Teaching Hospitals Complex Administration Act, 2016 	<ul style="list-style-type: none"> Sierra Leone Health Service Commission Act (<i>revision</i>) National Public Health Agency (<i>new</i>) SLESHI Act (<i>new</i>) National Medical Supplies Agency Act(<i>new</i>)
Regulation of Personnel and Substances	<ul style="list-style-type: none"> Medical Practitioners and Dental Surgeons Act, 1966; amendment (2008) Nurses and Midwives Board Act The Pharmacy and Drugs Act, 2001 The National Drugs Control Act, 2008; Amendment (2008) 	<ul style="list-style-type: none"> Allied Health Professionals Act(<i>new</i>) Nurses and Midwives Council Act (<i>revision</i>) Pharmacy and Drugs Act(<i>revision</i>) Food Safety Act(<i>new</i>)

Objectives, Actions and Targets:

While a number of the Acts noted above provide a strong legal basis for the MoHS’ delivery of healthcare in Sierra Leone, there are also a number of areas that require reform over the period of the HSSP II – 2017 - 2021. The following legislative shortfalls will be addressed over this period.

⁸There is no current legislation on the rights of health system users or workers

- **Strategic Objective 1:** Create a dedicated legal unit within the MoHS to improve the legislative framework for health in Sierra Leone.
 - **1.1. Establish a legal unit within DPPI:** The MOHS will establish a dedicated unit – with at least one lawyer – to advise and supervise all health sector legal reforms. The unit’s responsibilities will include working with the MoHS leadership, Directorates, Programmes and Units to develop or refine pieces of legislation; collaborating with the Ministry of Justice Law Officer’s Department to formally develop new Acts; and to shepherd legislation through the entire legal process, including gazetting, pre-legislation and reading/debate on the floor of Parliament.

- **Strategic Objective 2:** Improve the legislative framework that governs the health sector
 - **2.1. Improve the general sector governance through a new Public Health Act:** The greatest legislative gap at present is the need for a new Public Health Act to replace the Public Health Ordinance Act, 1960. Such a revision could help more clearly define the MoHS’ governance structure and responsibilities with respect to the GoSL’s other line Ministries as well as the Sierra Leonean Public. Areas for revision include:
 - a. Role and responsibilities of national and sub-national stakeholders:** Building on the Local Government Act (2004), clarifying the devolution of power to district, chiefdom and health facility levels. For instance, increasing the functionality and efficiency of the health system by improving administration systems for HRH and other activities.
 - b. Specific health issues around which there is no legal framework:** Advance a legislative framework for areas that are not covered, for example, public health emergencies.
 - c. Rights of health system users and workers:** No legislation exists at present. This could be addressed either through a ‘Charter of Patients Rights’. Such a document would cover the right to confidentiality and the right to full information on their condition, possible risks involved in treatment, etc.
 - d. International obligations:** Implementing obligations under international law - namely, the International Health Regulations – 15 June 2007 – or the Framework Convention on Tobacco Control – 22 May 2009. For the FCTC, for example, a requirement would be obliging manufacturers and importers of tobacco products to disclose to governmental authorities information about the contents and emissions of tobacco products.

 - **2.2. Revise or develop legislation for specific health issues, and especially mental health:** There are several pieces of legislation around specific health issues that have been created to support improved health outcomes, such as Acts related to HIV/AIDS and safe abortions (Section II above). However, a very serious gap in this area is the Lunacy Act, 1902. The legislation is outdated and creates structural challenges for the effective treatment of individuals with mental illness. This is especially important given the crises that Sierra Leone has faced in its recent history – the civil war and EVD epidemic – which have an important impact on morbidities related to mental illness.

 - **2.3. Revise or develop legislation for both existing and new health agencies or bodies:** Within the last decade, a number of new institutions have been created within the health sector to manage or advance critical areas of work, such as health worker recruitment (Health Services Commission Act, 2011); the health sector supply chain (National Pharmaceutical Procurement Unit, 2012); and key HRH issues related to medical education (Council for Postgraduate Colleges Act, 2016 and Teaching Hospitals Complex Act 2016).

Planned revisions will proceed and will help refine and improve the mandate of the Health Services Commission; replace the National Pharmaceutical Procurement Unit with a new institution (National Medical Supplies Agency Act); and establish a new public health agency (National Public Health Agency Act) and insurance agency (Sierra Leone Social Health Insurance Act). These are positive advancements, though the MoHS will be wary of fragmentation across a variety of different agencies.

- **2.4. Revise or develop legislation for the improved regulation of health personnel:** Finally, there is a starting regulatory framework for personnel – doctors, dentists, nurses, midwives and pharmacists, but some of the legislation is old and requires revision. Both the Nurses and Midwives Board and Pharmacy Board are already planning to revise their legislative mandates; while allied health professionals, such as Community Health Officers and laboratory professionals, are hoping to establish a new council for the regulation and supervision of these professions.

B. MoHS Structure, Staffing and Capacity

Current Status and Situation Analysis

The legislative framework described above articulates the basic structure and function of the MoHS as a normative body (setting policies and standards); a regulatory body (enforcing those standards); a coordinating body (ensuring stakeholders are aligned under a common vision); and a service provider (providing healthcare at the district level). The legislative framework does not, however, provide easy answers regarding how the health sector should best be managed from an operational perspective to deliver the best possible health outcomes to the people of Sierra Leone.

As a low-income country with myriad health issues, the leadership and staff of MoHS have to navigate daily a series of financial, technical and organizational-related issues to execute their work and keep the health system running. The following chapters will cover the financial and technical challenges that MoHS faces in some depth; this section will instead focus on critical organizational challenges.

- **MoHS Structure:** Improvements will be made to the current structure of the MOHS, including updating the organizational chart, mapping relationships with semi-autonomous entities (e.g., the NMSA) and its other line Ministries. It will also consider new changes, a management and structural assessment with the specific purpose of understanding and articulating the structure of the organization best suited to fulfilling its function.
- **MoHS Staffing:** The current staffing capacity of the MoHS is insufficient to deliver on its considerable tasks. The most critical gaps are at the middle-manager level, with many Directorates insufficiently staffed with driven early-to-mid-career professionals. Staffing levels vary widely, and often go hand-in-hand with the existence of external donor resources to partially or wholly cover specific salaries, often on a temporary basis.
- **MoHS Capacity:** There are limited training opportunities within Sierra Leone to improve leadership and managerial/administrative capacities for key senior and mid-level staff within MoHS. Those trainings that do exist often are provided only in other countries, and can take senior MoHS staff out of work for weeks at a time. A Leadership and Capability training course recently operated by the President’s Delivery Team has been an exception to this.

Objectives, Actions and Targets

- **Strategic Objective 3:** Assess and improve the structure, staffing and capacity of the MoHS
 - **3.1. Improve the organizational structure of MoHS:** The MoHS will conduct an organizational assessment to better understand the structural (non-staffing) gaps that prevent MoHS from better fulfilling its functions. The assessment will seek to answer whether the current organizational and reporting relationships among MoHS leadership, directorates, programmes, units, agencies and other bodies can and should be streamlined, including a critical eye towards whether the current list of different MoHS entities is appropriately tailored to the challenges at hand.
 - **3.2. Assess and enhance the MoHS staffing structure:** Once the structure of the institution has been assessed and decisions taken on any necessary changes, the MoHS will compare its current headcount to any necessary additions or subtractions implied by an adjusted structure. The MoHS will try and fill these gaps directly by making the case with the Human Resources Management Office (HRMO) for staffing changes; or by seeking organizational resources from the health development partners as appropriate.
 - **3.3. Develop and publish a full organizational chart of MoHS:** Any new MoHS structure and staffing will be codified in a publicly available organization chart, with staffing leads and contact info, to facilitate communication and understanding within the MoHS, across line Ministries, and with a variety of other health stakeholders.
 - **3.4. Develop and improve administrative practices and scheduling:** Given its limited staff complement relative to its mandate, the MoHS can struggle to manage the regular deluge of meetings, workshops, travel requests and other such activities that staff are regularly called to participate in. This can lead to periods of time – sometimes entire weeks at a time – when staff are out of the office, often due to a lack of coordination among donors and development partners scheduling events and making requests. The MoHS will establish a coordination function through which a) staff travels, especially out of the country, are approved; and b) the scheduling of activities, workshops, launches, and so on are organized and approved by MOHS – not driven in large part by external parties.
 - **3.4. Invest in MoHS leadership and capability training:** As noted above, MoHS faces a number of capacity gaps. These can, however, be addressed in part through targeted and practical trainings that provide guidance on project management; memo writing; IT skills, etc. Any leadership and capability training will be competency focused, and *any training will not take individuals out of the country or even out of post for any extended periods of time, which has sometimes been the case in recent years.*

C. Subnational Management and Decentralization

Current Status and Situation Analysis

As described above, the subnational management of health in Sierra Leone is often variable across districts, and governed by customary rather than statutory guidelines.

At the national level, a number of different ‘master’ facility lists exist, with estimates of peripheral health units (PHUs) varying by 50-100 facilities across different lists. In addition, there is no process by which new facility openings or closings are approved across the central MoHS, DHMTs and district councils. Anecdotal information suggests that new facilities are often opened by local politicians or other stakeholders, sometimes without MoHS awareness. Coordination between central MoHS, DHMTs and district councils remains relatively weak and unstructured; coordination between DHMTs and implementing partners remains a significant point of contention with the sector, with donor-funded IPs still occasionally embarking upon projects without the knowledge of the relevant DHMT in which the project is taking place.

In terms of devolution and district-level management of health, the Local Government Act –passed in Parliament in 2004 – outlines a broad plan for the devolution of the management of basic services to a set of newly created local councils which have “the highest political authority in the locality...and shall be responsible, generally for promoting the development of the locality and the welfare of the people in the locality...” However, the planned devolution of responsibility to the councils for health (among areas) has not always been matched by a devolution of resources and decision-making power. In particular, the HSSP 1: 2010-2015 review team found that the councils have limited ability to make discretionary decisions around funding, and no ability to make decisions regarding MoHS staffing and payroll, which remain centralized above even the MoHS – with the Human Resources Management Office. Composition and levels of engagement with the councils among health stakeholders vary broadly from district to district, although the HSSP review team also found that good working relationships appear to exist between the local councils and the DHMTs.

At the facility level, a number of community and chiefdom level structures – such as facility management committees and village development committees – variably exist and function across the districts, but generally not in a streamlined and consistent way.

Objectives, Actions and Targets

- **Strategic Objective 4:** Address the challenge of the devolution of health management
 - **4.1. Devolve finance and HR responsibilities over time:** It is difficult for the district councils and DHMTs to be *accountable* for health in their district if they are also not *responsible* for the tasks that would allow them to influence health management and outcomes. This will require a series of assessments and conversations between MoHS, MLGRD, MOFED and HRMO to plan out a (likely multi-year) process; and accompanying training and support to the district-level structures that would have to take on more responsibility.
 - **4.2. Continue to improve coordination among MoHS, partners and DHMTs:** The implementation of a new Service Level Agreements (SLA) Unit, described below, has helped reduce instances of IPs engaging a district without the awareness of the relevant DHMT and district council. However, there remains a stark divide in communication and coordination between district and national level stakeholders; coordination and idea-sharing across districts does not appear to occur in any regular manner. The MoHS will consider ways in which to ameliorate this issue, such as compulsory all-DMO meetings every quarter, or perhaps – in the context of delivering new and innovative solutions to MoHS’ structural challenges – considering the establishment of a district coordination

office / post that would be specifically dedicated to this issue. Districts will approve projects before SLAs are approved at the central level.

- **Strategic Objective 5:** Establish much greater knowledge and control of facility management
 - **5.1. Validate, publish and maintain a master facility list:** The lack of a master facility list is extremely challenging from an operational perspective; considering the challenge of allocating and posting staff or rationing and distributing drugs from limited pools of resources when the total number of service delivery points remains unclear. To address this challenge, the MoHS is finalizing a master facility list, and will validate and publish – quarterly, with changes – a list of currently operating health facilities, their service level designation (e.g., MCHP, etc.), and the name and contact details of the in-charge. A designee within the MoHS structure will be responsible for maintaining this information.

5.2. Establish processes for the opening, accreditation and closing of health facilities:
In addition to establishing the core list of facilities, the MoHS will use the current process opportunity of the Primary Health Care handbook review to articulate

 - **Process for facility openings:** A process of application and approval for the opening of a new health facility, or to change the level of care designation for a facility. This will include the description of who can apply, who can approve, and what the process looks like.
 - **Process for facility accreditation:** A process by which facilities are ‘accredited’ as being sufficient purveyors of quality services as described in the BPEHS. All existing health facilities operating under the purview of MoHS will be required to seek such an accreditation – at present, there is no regular assessment of service quality, nor any central level consequence to facilities that provide low-quality services, routinely charge FHC patients, etc.
 - **Process for facility closings:** A process by which underutilized, underperforming or otherwise unequipped facilities can be assessed and closed down. For example, the recent 2015 MoHS payroll cleansing demonstrated that nearly 100 facilities have *zero staff on MoHS payroll* – and are staffed instead by unpaid volunteers, who are known to charge FHC patients.
 - **5.3. Roll out new FMC guidelines at the chiefdom and community level:** At present, there is no consolidated and available list of varying governance structures – facility management committees, village development committees, and other such groups – that play a role in governing and monitoring the MoHS’ 1,200 health facilities. The MoHS will conduct an assessment across the health facilities to understand which health facilities have such a structure, and subsequently ensure that the new FMC guidelines – developed by MoHS with support from JSI – are rolled out quickly.

D. Inter-Ministerial Coordination for Multisectoral Action on Health

Current Status and Situation Analysis

The MoHS is the lead agency in the health sector in the country. However, there are a great many aspects of healthcare delivery that involve other line Ministries within the structure of the GoSL. These relationships are partly coordinated at the Cabinet level in terms of high-level strategic decisions that

rise to Minister-level decision making. Too often, however, these critical relationships function informally on an operational level, without clear institutional linkages and arrangements to maintain consistently strong coordination across the sectors. Other line Ministries that have a role to play in the health sector include:

- **Ministry of Finance and Economic Development:** MOFED is responsible for working with the MOHS to set its annual budget and coordinate the release of funds for recurrent expenditures and capital investment projects. MOFED also disburses salaries through the HRMO.
- **Ministry of Education, Science and Technology:** MEST is responsible for the administration of certain institutions of higher education, such as the College of Medicine and Allied Health Sciences, which are responsible for training health workers. In addition, the MEST oversees educational institutions that are critical platforms for health education and linkages to health services to ensure health for children and young people attending pre-primary, primary, middle school, and higher education.
- **Ministry of Local Government and Rural Development:** MLGRD is responsible for all policies and activities related to local government and decentralization as well as the district councils – which manage funding from MOFED across sectors at the sub-national level.
- **Ministry of Gender and Social Welfare:** MGSW is responsible for the non-health welfare of a variety of groups – for example – Ebola survivors and the destitute, both of which are populations meant to receive free health services under the FHC initiative.
- **Ministry of Agriculture, Forestry and Food Security:** MAFFS is a key player on a variety of issues that are critically important to the Directorate of Nutrition within the Ministry of Health, and the development of the Nutrition Strategy deeply involves MAFFS.
- **Ministry of Water Resources:** The Ministry of Water Resources is responsible for the provision of clean and potable water, which is critical for the overall function of and infection prevention and control in health facilities and also links to the MoHS' work in environmental health and sanitation – which is sometimes overlooked.
- **Ministry of Energy:** The Ministry of Energy is the sector lead on electricity, which is a key amenity that should be present at all of Sierra Leone's health facilities.
- **Ministry of Information and Communication:** The Ministry of Information and Communication is responsible for managing the ICT infrastructure and deploys ICT staff to the MOHS to maintain ICT infrastructure and manage the DHIS2 server on behalf of the MoHS. In view of the increasing adoption of digital health solutions and use of ICT in the management of health data, the Ministry of Information and Communication is a key player in the health sector.

Objectives, Actions and Targets

- **Strategic Objective 6:** Improve inter-ministerial processes and systems for health
 - **6.1. Map all inter-ministerial processes that are key to a well-functioning health sector:** The MoHS will produce a short, concise analysis of all areas of the sector in which the success of the MoHS hinges on processes or coordination with other Ministries within the GoSL framework. This will clearly map out the specific directorates and programmes within the various Ministries that need to work more closely together, and articulate how these entities rely on each other to deliver results.

- **6.2. Establish or improve coordination processes between MoHS and the other line Ministries:** Based on the landscape effort, the MoHS and its core partner Ministries will determine the manner in which coordination will be improved across several themes, such as improving existing processes or initiatives (e.g., organizing clear budget ceilings from MOFED through HRMO during the annual manpower planning process) or establishing new processes or initiatives (e.g., engaging MLGRD in further decentralization work, described below). This could result in a playbook for inter-ministerial coordination on health, with any attendant new or improved coordinating committees or bodies established.

E. Health Stakeholder Coordination

Current Status and Situation Analysis

Given the financial and technical challenges facing MoHS (as well as many other GoSL line Ministries), the health sector tends to be pluralistic. A broad range of different actors – the MoHS, bilateral and multilateral donors, UN agencies, local and international NGOs, and community and faith-based organizations – all play a role in both the strategic and operational activities of the sector. The funding implications of this pluralism are further discussed in the Chapter on health financing. Several coordination mechanisms exist to facilitate coordination in the sector:

Service Level Agreements (SLA) Unit: The SLA Unit, created by the MoHS in 2015, was designed to address a rising number of coordination challenges between the MoHS central and district offices and the NGOs funded to deliver services at the sub-national level. In order to help streamline the tremendous amount of activity in the sector, all implementing partners are now required to sign an agreement with the central Ministry as well as the relevant DHMT(s) and district council(s) that serves as a formal recognition on behalf of the government that the IP in question is delivering an agreed upon service for the sector that is aligned with national priorities.

Despite efforts to improve the roll-out and management of the SLAs, challenges – and occasional disagreements – remain between MoHS and its partners over fee structures and reporting issues. DHMTs continue to voice concerns that they are out of the loop, including recent instances of IPs leaving their districts with work unfinished without informing the DHMTs of their impending departure.

Coordinating bodies chaired by MoHS: There are, in addition, a number of coordinating bodies convened by the MoHS to facilitate discussions among key players in the sector

- **Health Sector Coordinating Committee:** The HSSC is the highest coordinating body in the sector for the MoHS and its development partners. The quarterly meetings are chaired by the Minister, with a closed list of invitees from amongst donors, UN agencies and other stakeholders. The meeting is designed to provide a forum for leading actors in the sector jointly take strategic decisions.
- **Health Sector Steering Group:** The HSSG is a monthly coordinating group, chaired by the Chief Medical Officer, which is designed to tackle more operational and technical issues that arise in the health sector, as well as to provide key updates from the MoHS to its many partners. The invitation list is open, and the meeting is attended by a broad range of health sector stakeholders.
- **Technical working groups:** A very broad range of working groups of different shapes and sizes also exist across a range of different focus areas. These are most often chaired by the relevant MoHS Directorate or Program, and involve a combination of MoHS and external stakeholders as required.

- **Management meetings:** The CMO chairs monthly meetings with directors and programme managers, and quarterly meetings with DMOs.

Coordinating bodies chaired externally from MoHS: In addition, there are several other fora to promote coordination on specific issues or among specific partners:

- **Country Coordination Mechanism (CCM):** The CCM, which includes government donor, NGO and community stakeholders, oversees the implementation of grants financed through the GFATM.
- **Health Development Partners (HDP) forum and Health NGOs forum:** The HDP forum and Health NGOs forum both meet monthly. The HDP Forum is generally attended by donors, UN agencies, and NGO consortia representatives. The Health NGOs forum is attended by both local and international NGOs. Both are occasionally attended by government stakeholders in order to brief the partners on various activities and issues. The main purpose of both fora is to share information.

Objectives, Actions and Targets

- **Strategic Objective 6:** Improve relationships and joint accountability for health sector outcomes among MoHS and its partners
 - **6.1. Support the SLA unit to improve its processes, systems and coordinating abilities:** The MoHS will aim to capacitate the SLA unit with the resources required for it to, in particular, focus on improved communication and coordination among MoHS, DHMT and partners; and routine resource mapping efforts, in collaboration with the Healthcare Financing Unit, in order to feed into the MoHS' health financing work.
 - **6.2. Revitalize the HSCC:** The HSCC is the most critical joint governance body between MoHS and key partners in the space, but it meets sporadically. The HSCC standing members will redevelop and agree the TORs; increase the frequency of these meetings to bi-monthly or monthly instances, with a published calendar on the MoHS website; and develop a mutual accountability performance framework, per the recommendation of the HSSP I review team.
 - **6.3. Make health sector coordination more transparent:** Few individuals have a clear overview of all the various coordinating groups that govern the health sector. The MoHS will update its website with the list of the groups described above, with points of contact for interested parties to get engaged; and work to ensure that key documents, meeting minutes, etc. are continually made available.

F. Planning and Prioritization

Current Status and Situation Analysis

Sierra Leone's health sector has reached an unusual juncture regarding its planning and prioritization work. Sierra Leone's last HSSP drew to a close in 2015; since then, the sector has largely moved – at a macro level -- in line with the priorities and activities set out in the various recovery plans that were put in place in 2015 at the tail end of the Ebola epidemic, such as the National Health Sector Recovery Plan and the President's Recovery Priorities (PRP). Now, the PRP is drawing to close in June 2017 – and the health sector will need a new overall strategic direction to follow over the coming years.

At the same time, given the significant donor resources that poured into the health sector during and after the Ebola epidemic, there has been an unprecedented amount of plan and policy development at the sub-sector level, which has resulted in the many recently launched or soon-to-be-launched plans and policies described in the introductory section. These plans and policies have largely been led and launched at the Directorate and Programme level, which has meant that – while a significant amount of good work has been done – these plans and policies were developed to varying standards, degrees of complementarity and overlap. The planning processes used for these efforts have not always been fully participatory, including or excluding key MoHS directorates, district stakeholders, communities and/or partners. They have not always been driven by data and evidence to guide objectives and interventions. And they have not always resulted in prioritized, easy-to-digest, well-costed documents.

Realistically, it will take a significant amount of time to join health stakeholders in Sierra Leone around a commonly held vision. With all of the activity described above, many stakeholders – both government and partners – have already put in place plans, budgets and funding over the coming years. However, the new HSSP provides a unique moment to try and tie all of the diverse activities within the health sector more closely together, and encourage that any new initiatives began to fit more closely into an overarching vision – and a sector wide approach – described and shared by the MoHS and its partners.

The following objectives respond to the challenges described above, and chart a path towards a clear, coherent and prioritized vision – embodied within an agreed upon HSSP – that lays out the pathway for the sector over the next five years; a process by which any new plans and policies are slotted into that vision over time; and a process by which all efforts within the sector – whether by MoHS or partners – are streamlined towards a common direction and purpose.

Objectives, Actions and Targets

- **Strategic Objective 7:** Improve and streamline future planning and policy processes
 - **7.1. Articulate baseline standards for all MoHS plan and policy development:** The MoHS will put forth guidance through DPPI on the process by which key MoHS staff can begin a new policy or strategic planning process; as well as expectations on how these processes will be participatory (minimum thresholds for consultation); driven by evidence (minimum standards on data-driven decision-making); and the standards for document development, prioritization and costing (minimum standards for the resulting document itself). DPPI will be equipped as a clearinghouse to provide this guidance.
- **Strategic Objective 8:** Begin to chart a course towards a sector-wide approach as opposed to project-based health interventions
 - **8.1. Work towards bringing all health stakeholders 'on plan' over the medium term:** As recommended by the HSSP I review team, the MoHS and partners will work together to ensure that a) existing projects fit within the overarching spirit and direction of the HSSP II as possible; and that b) new projects do not diverge significantly from the agreed upon plan for the country. This will be a difficult task, and will require concerted effort and partnership among MoHS leadership, key bilateral and multilateral donors and other health stakeholders.

- **8.2. Introduce compulsory budget transparency:** In order to help facilitate activity 8.1., the MoHS will introduce compulsory budget transparency – at a granular level of detail – into its SLA processes so that an annual resource mapping can be produced. This resource mapping will offer a clear comparison between what development partners are funding and implementing as compared to the objectives laid out in this plan.
- **8.3. Consider bringing all health stakeholders ‘on budget’ over the long-term:** A much more difficult task would be to bring all key health stakeholders into the same budget, either through parallel funding mechanisms or a pooled fund arrangement. As this will not be credibly achieved before the HSSP II mid-term review, the MoHS will revisit the feasibility of this potential activity at the end of year two of the plan.

G. Private Sector Healthcare

Current Status and Situation Analysis

There is a considerable gap in knowledge and data on the private sector for healthcare in Sierra Leone. The private sector appears to be an important provider of services, especially a) in terms of health service provision at the secondary and tertiary level, with many hospitals known to be in operation across the country, and b) a considerable network of private sector pharmacies and informal drug peddlers. However, the sector is not formally organized around a series of trade associations, and data on utilization and sales either does not exist or is not easily accessible. Regardless of these gaps, the private sector will be considered as part of the overall approach to improving healthcare in Sierra Leone. Several new initiatives are already considering the role of private sector pharmacies, for example, including an effort to organize a network of providers who can provide drugs to Ebola survivors.

As part of the governance efforts under the HSSP, the MoHS will seek to commission new research and landscape analyses to better understand and engage private sector providers.

Objectives, Actions and Targets

- **Strategic Objective 9:** Understand, engage and organize the private sector for healthcare
 - **9.1. Commission a private sector landscape analysis:** The first step will be to understand the scope of private sector activities on healthcare in Sierra Leone. This will produce a clear overview and database of private sector hospitals, clinics, laboratory service providers and registered pharmacies, as well as some estimation of unregistered pharmacies and drug peddlers. Some comparison of public vs private sector utilization, service quality and cost will also be included as part of the exercise.
 - **9.2. Develop a strategy to engage and organize the sector:** Based on the landscape, the MoHS and its partners will come together for a series of discussions with key private sector stakeholders to discuss how the private sector can be better engaged in order to deliver improved health outcomes to the people of Sierra Leone. This may include the establishment of key bodies and associations – such as an association of private sector hospitals – that would help the public and private sectors engage in a more organized fashion. This should yield a private sector engagement plan that can be an addendum to the HSSP.

CHAPTER 2: SERVICE DELIVERY

A. Relevant Strategy and Policy Documents

This chapter covers the most significant portion of activity in the health sector, and aims to provide an overview of the breadth and depth of MoHS service delivery activities. The remainder of this section attempts to provide an overview of service delivery in Sierra Leone across a number of areas, along with key activities for the HSSP II period.

B. Current Status and Situation Analysis

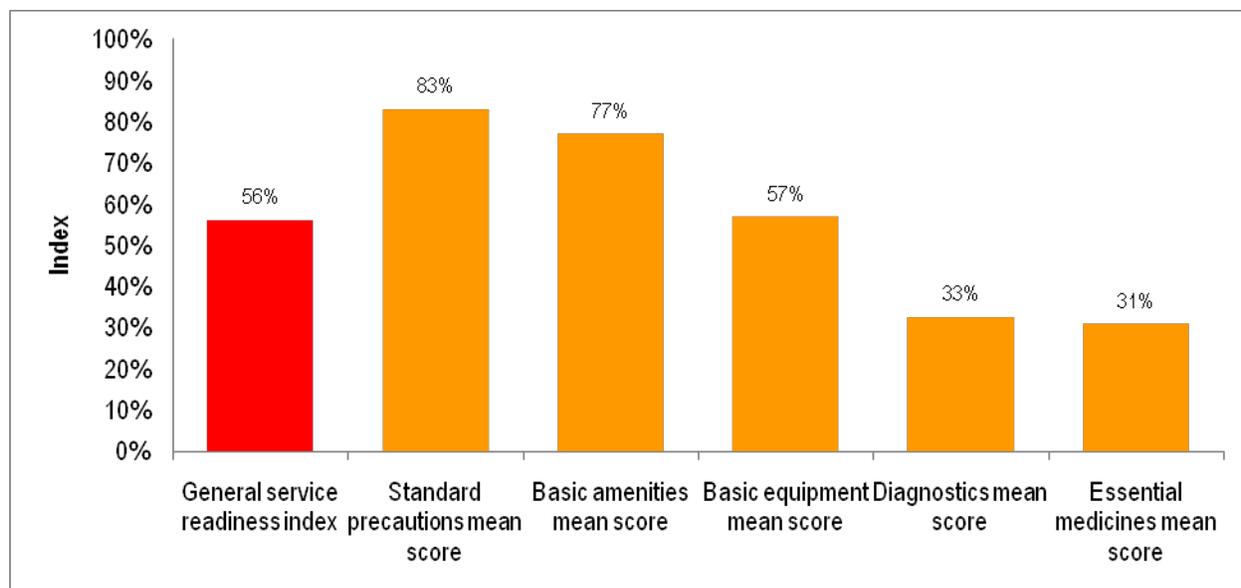
As suggested by Sierra Leone's health indicators, the health system in Sierra Leone struggles to provide high-quality care to its citizens for a number of reasons:

- **Accessibility:** Despite the significant number of health facilities in Sierra Leone, distance to facilities – especially from hard to reach areas that lack transport – prevents some Sierra Leoneans from seeking care. Additionally, the community health worker (CHW) programme that brings preventive care and high impact lifesaving interventions to household level, including in hard to reach areas, as well as promotes referrals and positive health seeking behaviours, is not yet scaled up, operational and institutionalized. Further inequities are driven by levels of education, level of income and urban vs. rural location. There is not yet a functional system of referrals to move patients through various levels of care accordingly to the severity of their illnesses – although a National Emergency Medical Service (NEMS) is planned.
- **Affordability:** Perhaps the most significant barrier to services for Sierra Leoneans is cost. Out-of-pocket expenditures as a proportion of all health expenditures are extremely high, at a 61%. While the Free Healthcare Initiative (FHCI) was meant to cut down on user fees for the most vulnerable, consistent reports from the subnational level suggest that patients in this category continue to be charged, which is in part driven by the high numbers of unsalaried staff that populate Sierra Leone's health facilities.
- **Availability:** Provided patients are willing to overcome these barriers to access, the availability of services remains poor. At a policy level, a national standard for the provision of care has been defined – the BPEHS – but most health facilities have limited ability to provide the services described in the document. This is partly driven by the commendable ambition of the BPEHS architects, and partly by the lack of skilled staff, medical products, and basic amenities at health facilities. Specialized care does not exist below the hospital level.
- **Quality:** Poor quality of services is a significant issue in the country. This is linked to a variety of factors including absence/poor dissemination of standards, guidelines and job aids, weak supervision, mentorship and monitoring systems in health facilities and absence of quality improvement mechanisms including audits and regular reviews of performance in health facilities.

A recent Service Availability and Readiness Assessment (SARA), conducted by DPPI in close collaboration with WHO, provides additional clarity around questions of availability, readiness and quality. While the

data is still being analyzed, initial results suggest there are serious gaps across these metrics. The average service readiness index across 1,283 facilities – which measures the presence of basic amenities, basic equipment, standard precautions, diagnostic capacity and essential medicines – is only 58%. The individual metrics vary widely, with only one third or less of all facilities offering sufficient diagnostic capacity and essential medicines. The SARA also provides data on the availability of health services across particular diseases and conditions, which also vary widely.

Figure 4: SARA 2017 Results – General Service Availability



A rapid survey was also conducted recently of in-charges in the North, East and South regions, which yielded similar results. In-charges were asked to identify the *most* significant barrier to delivering quality services in their facilities. The top two issues identified – by a wide margin – were the availability of drugs and medical supplies as well as the availability of appropriate health infrastructure.

Barriers to Service Delivery	North	East	South	TOTAL
Governance & accountability	31	16	19	66
Availability of drugs and medical supplies	159	67	80	306
Availability of trained health workers	27	19	18	64
Availability of adequate financial resources	20	17	42	79
Data use for planning	10	6	5	21
Health infrastructure	79	83	75	237
Availability of the necessary hospital equipment	23	13	37	73
Public and environmental services (WASH)	22	13	34	69
Adequate community support in health service delivery	7	6	5	18
Barriers to service uptake	7	2	2	11
	385	242	317	944

The main feedback from the in-charges in health facilities were that the MOHS should prioritize procurement of essential medicines, moving away from ‘push’ system to that of a ‘pull’ one. They also highlighted the need for structural improvements and ensuring basic facilities (e.g., toilets, running water, etc.) and equipment are made available.

Finally, service delivery is also dependent on the strengths of the health system pillars that are a necessary (though not fully sufficient) precondition for the provision of good quality health services. The following chapters are dedicated to four areas – human resources for health, medical products and technologies, health financing, and health information systems – that support service delivery. These topics will not be covered in depth here:

- **HRH:** A lack of skilled staff at all facility levels (Chapter 3)
- **Health financing:** Limited access to financial resources at facility level, which impact maintenance and utilities (Chapter 4)
- **Medical Products and Health Technologies:** Inadequate provision of medical products and supplies, including the availability of pharmaceuticals and consumables as well as laboratory services, (Chapter 5)
- **Information Systems:** Insufficient health information for the DHMTs and central Ministry to respond rapidly and well to an assortment of problems and issues (Chapter 6)
- **e-Health/digital health:** Innovative technologies that go beyond the scope of information systems and have implications for service delivery (Chapter 6)

Other critical determinants of service delivery, such as sociocultural barriers to access, community-based platforms, etc., are described in more depth as appropriate in their individual strategies.

C. Objectives, Actions and Targets

- **Strategic Objective 1:** Revise health policy documents that describe MoHS obligations and expectations towards service delivery at the facility level:
 - **1.1. Conduct a mid-term review of the 2015 BPEHS:** The BPEHS, which was launched in mid-2015, is nearly due for a mid-term review. Since its launch, many stakeholders inside and outside of government have noted that the standards described within the document are unrealistic within the resources and staffing available to MoHS. In addition, some areas – such as staffing norms – require significant revision. The MoHS will lead a process in late 2017 or 2018 to revise the document to reflect the current state and capacity of the health sector, and improve key areas of the document.
 - **1.2. Revise the Primary Healthcare Handbook:** The PHC Handbook is another critical document which is currently under revision (its last iteration was published in 2004). This document describes key policy principles and processes within the MoHS, such as the process for openings and closings of health facilities described above.
 - **1.3. Strengthen referral systems:** Referral systems cut across all health and nutrition programmes and serves to link community and facility health services. This actively is closely linked to review of the BPEHS and update of the PHC Handbook.

- **1.4. Disseminate and create awareness among health workers on policy and service expectations described in these documents:** Health workers knowledge of the current BPEHS is low, which is not unexpected given that half of workers in health facilities are unsalaried volunteers not presently on the MoHS payroll. Regional cascade trainings will be held with in-charges at minimum to promote knowledge and acceptance of a revised, realistic set of policy and service standards.
- **Strategic Objective 2:** Invest in infrastructure and systems that will improve the quality of care (*outside of HRH, medical products, health financing and information systems*)
 - **2.1. Target specific high-volume, high-value health facilities for infrastructure improvements:** Per the RMNCAH strategy, a recent UNFPA assessment regarding RMNCAH services noted ‘a lack of adequate space, inadequate water supply, and lack of infrastructure for waste management as well as lack of power supply⁵¹’ as key challenges. An immediate plan for facility refurbishment will be put in place, but with a major focus on the BEmONC and CEmONC health facilities.
- **Strategic Objective 3:** Introduce quality assurance and quality improvement interventions to deliver better healthcare services
 - **3.1. Develop central, district and facility QA and QI structures:** Throughout the consultations for this process, stakeholders continually raised concerns over the quality of services being provided – indeed that even if access was improved, outcomes might not change. There is not yet a clear working hypothesis around what an intensive QA and QI effort might entail, but there is a consensus that developing such a structure must be a critical part of the next HSSP.

D. A Review of Sub-Sector Plans for Service Delivery

In addition to the activities noted above, a significant amount of work has also been done on a number of sub-sector plans that are disease or population specific, and contain service delivery objectives. The following presents a series of snapshots of these sub-sector plans and some of their key features across a number of key areas. As noted above, this is just one example of how the level of activity in the health sector has driven significant amounts of new initiatives while not necessarily streamlining each of them in the context of a broader framework and set of MoHS goals. As a result, many of these documents link to HSS areas that may also have their own separate and individual strategies. These links to broader HSS needs, activities and reforms are highlighted throughout the following pages.

Reproductive, Maternal, Neonatal, Child and Adolescent Health
<p>Key Document and Status:</p> <ul style="list-style-type: none"> National Reproductive, Maternal, Neonatal, Child and Adolescent Health Strategy (2017- 2021) Final stages of dissemination
<p>Responsible Party within MoHS: Directorate of Reproductive and Child Health</p>
<p>Situation Analysis and Key Challenges:</p> <ul style="list-style-type: none"> Reproductive health and family planning: Knowledge of contraceptive methods is high in Sierra Leone, with roughly 95% of men and women reporting that they know of at least one method. Contraceptive use has also increased significantly, climbing to 16% in the 2013 GHS from 7% in the 2008 DHS – although this obviously remains quite low. The public sector provides the majority of contraceptive methods, serving nearly 70% of users.⁹ Maternal health: The most recent Sierra Leone DHS, conducted in 2013, estimated the maternal mortality rate (MMR) at 1,165 per 100,000 live births. Per Sierra Leone’s new RMNCAH strategy, approximately 6 % of women in Sierra Leone will die from maternal causes given the current mortality rate¹⁰. Leading causes of maternal death include bleeding, pregnancy induced hypertension, sepsis, and abortions, as well as other indirect causes.¹¹ Neonatal and child health: Sierra Leone’s infant and child mortality rates are also among the highest in the world. The under-five mortality rate is estimated to be 156 deaths per 1,000 live births; the under-5 mortality rate is estimated to be 156 deaths per 1,000 live births; and the neonatal mortality rate is estimated to be 39 deaths per 1,000 live births.¹² Malaria (see below), diarrhea and acute respiratory infections remaining leading causes of death.
<p>Vision, Mission Goal:</p> <ul style="list-style-type: none"> Vision: A Sierra Leone where there are zero preventable deaths of women, newborns and children, where women and adolescents have their reproductive health needs met, and where women, newborns and adolescents not only survive but thrive and live to their fullest potential. Mission: Promoting health and wellbeing of all women, newborns, children and adolescents in Sierra Leone through implementation of evidence based high impact RMNCAH interventions, and creating an enabling environment for effective delivery of quality RMNCAH services at all levels of health service delivery. Goal: Accelerate reduction of preventable deaths among women, newborns , children and adolescents and promote their health and wellbeing
<p>High-Level Targets:</p> <ul style="list-style-type: none"> Overall Objective: To increase access to and utilization of quality evidence based RMNCAH high impact interventions at all levels of service delivery. **Coverage targets for 18 indicators available within the main strategy document**
<p>Key Objectives:</p> <ul style="list-style-type: none"> Strategic Objective 1: Strengthened health systems for effective provision of RMNCAH services Strategic Objective 2: Improved quality of RMNCAH Services at all levels of RMNCAH service delivery Strategic Objective 3: Strengthened community systems for effective delivery of RMNCAH services Strategic Objective 4: Enhanced research, monitoring and evaluation for effective delivery of RMNCAH services
<p>Description of Costs (if available):</p> <ul style="list-style-type: none"> The strategy is estimated to cost \$544.9M (strategy scenario) over the 2017 – 2021 period <i>However, many of these costs overlap with the various HSS strategies that have been developed – human resources,</i>

⁹ Statistics Sierra Leone, Sierra Leone Demographic and Health Survey 2013, 2014, <https://dhsprogram.com/pubs/pdf/FR297/FR297.pdf>

¹⁰ Ibid

¹¹ Ministry of Health and Sanitation, *Maternal Death Surveillance and Response Annual Report 2016*

¹² Statistics Sierra Leone, Sierra Leone Demographic and Health Survey 2013, 2014, <https://dhsprogram.com/pubs/pdf/FR297/FR297.pdf>

supply chain, and information systems in particular.

Health Systems Crossover

- Strategic Objective 2 and 3 directly relate to human resources for health as they aim to improve both the quality of services as well as the effective delivery of services.
- Strategic Objective 4 aims to strengthen national HIS to ensure responsiveness to RMNCAH information needs

Immunization

Key Document and Status:

- EPI Comprehensive Multi-Year Plan (2017- 2021)
- Draft ready for discussion to be followed by validation

Responsible Party within MoHS: EPI Programme

Situation Analysis and Key Challenges:

- **Immunization:** The current target population for the Expanded Programme on Immunization (EPI) services in Sierra Leone includes all children under the age of one year and women of childbearing age (15-49 years). Although immunization coverage is relatively high in the country (DPT3 coverage for 2016 was at 84% across the country as per WHO/UNICEF estimates), challenges persist including in hard-to-reach areas, cold chain management and system-wide barriers (including inadequate health workforce and infrastructure gaps).

Vision, Mission Goal:

- **Mission:** Provide equitable access for all target groups, especially children and women of childbearing age (WCBA) to existing and new vaccines, and other interventions that lead to reduction of morbidity and mortality in Sierra Leone.
- **Goal:** To achieve at least 95% coverage for fully immunized child and 90% coverage for TT2+ in pregnant women in order to reduce maternal and child ill-health, disability and deaths attributable to vaccine preventable diseases by 2015.

High-Level Targets:

- High level targets linked to main goals

Key Objectives:

- Reduce measles mortality by 95% and morbidity by 90%
- Stop the transmission of wild poliovirus
- Attain and maintain a level of immunization coverage of at least 90% for children under one year for all vaccines given
- Immunize 75% of pregnant women with Tetanus Toxoid, as an effort towards reaching elimination of Maternal and Neonatal Tetanus
- Maintain and expand EPI cold chain

Description of Costs (if available):

- Total resource requirement of \$103M over the 2017-2021 period, of which \$85M is for routine immunization.

Health Systems Crossover

- Recruitment, deployment and retention of health workers as well as regular training and supportive supervision
- Management of equipment and services
- Reliable and timely quality data for decision-making
- Sustainable financing over the long-term, including domestic investments

Nutrition
Key Document and Status: <ul style="list-style-type: none"> National Food & Nutrition Security Implementation Plan – 2013 – 2017 Launched 2013
Responsible Party within MoHS: Directorate of Nutrition
Situation Analysis and Key Challenges: <ul style="list-style-type: none"> Nutrition: As of the 2013 DHS, roughly 38% of children under five, 9% are wasted, and 16% are underweight. Almost all children are breastfed at some point, although only one third are exclusively breastfed. Only 7 percent of children age 6-23 months are fed appropriately, and 80% of children age 6 – 59 months are anemic.
Vision, Mission Goal: <ul style="list-style-type: none"> Vision: A healthy and well-nourished population with communities and families well informed and empowered to take appropriate action on their food and nutrition situation. Goal: The overall goal of the policy is to contribute to the improved health, social and economic well-being for all the people in Sierra Leone, especially women, children and other nutritionally vulnerable groups.
High-Level Targets: <ul style="list-style-type: none"> Overall Target: To increase food production and consumption score by 80% and 25% respectively and reduce malnutrition rates among infants and young children in Sierra Leone by 30% by 2017 (Table 1). Stunting rates are expected to be reduced from 34.1% to 28.5% by 2017 because of its irreversible nature.
Key Objectives: <ul style="list-style-type: none"> Overall Objective: Improve the nutritional status of the population especially infants and young children, pregnant and lactating women in Sierra Leone. Objective 1: Increase commitment from policymakers, policy advisors, and programme designers at national and district levels to accord nutrition a high priority in the political and national development agenda. Objective 2: Improve household food security situation (quantity, quality and safety) in order to satisfy the daily dietary needs of the population. Objective 3: Improve the nutritional status through appropriate feeding practices of children under the age of 5 years and women of reproductive age (15-49). Objective 4: Strengthen preventative measures against nutrition related diseases. Objective 5: Improve access to quality curative nutrition services. Objective 6: Strengthen surveillance systems for monitoring the food and nutrition situation. Objective 7: Enhance evidence-based decision making on food and nutrition issues through research. Objective 8: Strengthen the effective and efficient coordination of food and nutrition interventions.
Description of Costs (if available): <ul style="list-style-type: none"> The plan was estimated to cost roughly \$129M USD over the 5 year implementation period
Health Systems Crossover <ul style="list-style-type: none"> Effective nutrition services depend on access to trained human resources to provide interventions as well as the nutrition commodities used to serve vulnerable populations.

HIV/AIDS
<p>Key Document and Status:</p> <ul style="list-style-type: none"> National Strategic Plan on HIV/AIDS – 2016 – 2020 Launched 2016
<p>Responsible Party within MoHS: National AIDS Secretariat; National AIDS Control Programme</p>
<p>Situation Analysis and Key Challenges:</p> <ul style="list-style-type: none"> The HIV epidemic in Sierra Leone is “mixed, generalized and heterogeneous.”¹³ Prevalence of HIV is estimated to be 1.5% (DHS 2013). Prevalence varies by location, and is particularly high in Western Area Rural (3.4), Western Area Urban (2.5) and Kono (2.5). An estimated 54,000 individuals are living with HIV as of 2015, including 5,000 children.¹⁴ Roughly 18,000 individuals are on ART as of the end of 2016.¹⁵ Prevalence among key populations above 5% (FSW,MSM,PWID)
<p>Vision, Mission Goal:</p> <ul style="list-style-type: none"> Vision: The vision for the NSP 2016-2020 is: A Sierra Leone where HIV is no longer a public health threat. Goal: Zero new infections; Zero discrimination; Zero AIDS-related deaths
<p>High-Level Targets:</p> <ul style="list-style-type: none"> To reduce HIV incidence among adults and adolescents by 50% from 0.04% in 2015 to 0.02 % by 2020. To reduce HIV incidence among infants born to HIV positive mothers from 13% in 2015 to less than 5% by 2020 To reduce HIV-related mortality by 86% for both adults and children by 2020. To increase domestic financing of the HIV response to 30% by 2020
<p>Key Objectives (Outcomes 1-7 on Prevention; Treatment, Care and Support; and Enabling Environment):</p> <ol style="list-style-type: none"> Young people, especially young women and adolescent girls, who access combination prevention services and are empowered to protect themselves from HIV increased from 2015 level to 90% by 2020 Key populations, including sex workers, men who have sex with men, transgender, PWID, EVDS, prisoners , TB patients, migrant workers (fisher-folk, miners, transporters) and traders, and uniformed personnel that access tailored HIV combination prevention services and are empowered to protect themselves from HIV, EVD and TB increased from 2015 level to 90% by 2020 New HIV infections among children eliminated and their mothers health and well-being is sustained 90% of all adults and adolescents who know their positive HIV status receive comprehensive treatment, care and support, including sustained antiretroviral therapy; and have durable viral load suppression People living with, at risk of and affected by HIV and EBV who report no discrimination especially in health, education and workplace settings increased from 2015 level to 90% by 2020 Women and men who practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV and EVD increased from 2015 level to three times that level by 2020
<p>Description of Costs, Resources and Gaps (if available):</p> <ul style="list-style-type: none"> As per the National Strategic Plan on HIV/AIDS, the total cost of the plan is estimated to be \$357M USD
<p>Health Systems Crossover</p> <ul style="list-style-type: none"> Community-based HIV counseling and testing and delivery of antiretroviral therapy through task shifting Large coverage gaps testing & treatment exist within health and community systems, and procurement and supply management remain weak. Coverage gaps also exist in number of health facilities and human resource providing HIV services. There is no health sector response-specific HIV plan Integration of HIV programming into District health care delivery system including distribution of HIV commodities to PHUs

¹³ Sierra Leone HIV National Strategic Plan: 2016 - 2020

¹⁴ Ibid

¹⁵ Ministry of Health and Sanitation 2016 Annual Review – National AIDS Control Program Presentation

TB
Key Document and Status: <ul style="list-style-type: none"> National Leprosy & TB Strategic Plan – 2016 – 2020 Launched 2016
Responsible Party within MoHS: National Leprosy & TB Control Programme
Situation Analysis and Key Challenges: <ul style="list-style-type: none"> Roughly 14,000 cases were notified in 2016 (or 212 cases per 100,000 population). The treatment success rate is 86.7%, with 97% of TB cases being tested for HIV. A small number of leprosy cases (140) were diagnosed in 2016.¹⁶
Vision, Mission Goal: <ul style="list-style-type: none"> Vision: Sierra Leone free of Leprosy and Tuberculosis Goal: To reduce the Leprosy and Tuberculosis burden
High-Level Targets: <ul style="list-style-type: none"> Reach 85% of all people with TB and place all of them on appropriate therapy by 2020 By 2020, reach 75% of the key population, the most vulnerable, underserved and at risk populations with access quality TB treatment and care Reach 90% treatment success for all people diagnosed with TB through affordable treatment services adherence to complete and correct treatment and social support by 2020. Reach 75% of TB-affected families facing catastrophic costs due to TB by 2020 Leprosy eliminated in high endemic districts by 2020 Achieve disability grade 2 among newly diagnosed Leprosy patients to 5% by 2020.
Key Objectives (Objectives 1-13 from TB Plan): <ol style="list-style-type: none"> To increase TB case detection rate by 25% by 2020 through strengthening routine case notifications and addressing vulnerable groups of; prisoners, miners and diabetics and treat 90% successfully. To increase laboratory capacity for bacteriological diagnosis of TB and drug resistance assessment To enroll and treat 90% of all diagnosed DR-TB patients on appropriate treatment by 2020 To increase proportion of children cases aged under 15 years old, from 1.8% in 2014 to 8% among new Bacteriologically confirmed positive cases by 2020. To test all TB diagnosed clients for HIV and increase the percentage of co- infected patients enrolled for ART/CPT from 68% in 2014 to 100% and provide them with CPT and screen 90% of TB-HIV partners by 2020. To establish the magnitude of TB burden and risk drivers in the country and manage accordingly To reduce the incidence of disability grade 2 among newly diagnosed leprosy cases from 20% in 2014 to less than 5% by 2020 through enhancing early case finding and treatment of Leprosy patients To promote and respect patient’s rights while providing the best quality Leprosy & TB care based on individual needs To increase the number and proportion of new patients with TB (all forms) diagnosed and notified – (referred) by non-public service providers- (CHWs referral) and private health facilities from 24.1% in 2014 to 40 % by 2020. To establish the magnitude of L/TB impact and effects on the TB-affected families / reduce the effects by 75% by 2020 To develop and implement an efficient PSM system that ensures timely available and proper management of pharmaceutical and Health equipment and products. To strengthen quantitatively and qualitatively the managerial capacities of the Central Unit of the National Leprosy and Tuberculosis Program by 2020 To establish and strengthen an integrated ME system that can support accurately and efficiently the tracking of all identified indicators for measuring TB incidence and mortality.
Description of Costs, Resources and Gaps (if available): <ul style="list-style-type: none"> The total cost of the plan is estimated to be \$21M USD
Health Systems Crossover <ul style="list-style-type: none"> Medicines Products & Health Technologies: The strategic plan depends on efficient and effective delivery and availability of sufficient and quality drugs for Leprosy, TB and TB-HIV services. An improved lab is a key strategic priority. The TB Central Reference Laboratory is not yet equipped with modern and efficient diagnostic equipment. Human Resources for Health: Scaling up intensified case finding and reducing lost to follow up rates will depend on human resource capacity.

¹⁶ Ministry of Health and Sanitation 2016 Annual Review – National Leprosy & TB Control Program Presentation

Malaria
Key Document and Status: <ul style="list-style-type: none"> National Malaria Control Strategic Plan – 2016 – 2020 Launched 2016
Responsible Party within MoHS: National Malaria Control Programme
Situation Analysis and Key Challenges: <ul style="list-style-type: none"> Sierra Leone has one of the highest burdens of malaria in the world (Global Malaria Report), and the disease is estimated to be the number one cause of mortality in the country. Given this significant burden, malaria is estimated to account for approximately 2M outpatient visits to health visits every year as well as twenty percent of child mortality¹⁷
Vision, Mission Goal: <ul style="list-style-type: none"> Vision: Access to malaria control interventions for all Mission: To direct and coordinate efforts towards a malaria-free Sierra Leone through effective partnerships.
High-Level Targets: <ul style="list-style-type: none"> Goal: By 2020, reduce malaria morbidity and mortality by at least 40% compared with 2015
Key Objectives: <ul style="list-style-type: none"> Objective 1a: All suspected malaria cases should have access to confirmatory diagnosis Objective 1b: All malaria cases to receive effective treatment. Objective 2a: Provide access to 100% of the population at risk with preventive measures by 2017 Objective 2b: To protect at least 80 % of pregnant women and children under one year with IPT 3 by 2020 Objective 3: To provide knowledge to the population such that at least 80% practice malaria prevention and treatment measures by 2018. Objective 4: By 2020, at least 95% of health facilities report routinely on malaria programme performance. Objective 5: By 2020, maintain and strengthen capacity for program management, coordination and partnership to achieve malaria programme performance at all levels.
Description of Costs (if available): <ul style="list-style-type: none"> The strategy is estimated to cost roughly \$126M USD over 5 years
Health Systems Crossover <ul style="list-style-type: none"> Health Financing: There is inadequate funding for comprehensive implementation of interventions. . Medical Products: Stock out of antimalarial commodities at service delivery point; coupled with over stock and expiry of other antimalarial health products.

¹⁷ Sierra Leone Malaria Control Strategic Plan: 2016 - 2020

Neglected Tropical Diseases
<p>Key Document and Status:</p> <ul style="list-style-type: none"> • Master Plan for Neglected Tropical Disease Elimination – 2016 – 2020 • Launched 2016
<p>Responsible Party within MoHS: NTD Programme</p>
<p>Situation Analysis and Key Challenges:</p> <ul style="list-style-type: none"> • Sierra Leone’s burden of neglected tropical diseases includes Lymphatic Filariasis, Onchocerciasis, Schistosomiasis, Soil Transmitted Helminthiasis, Trachoma, Buruli Ulcer and Human African Trypanosomiasis. Guinea Worm Disease was eradicated in 2009.
<p>Vision, Mission Goal:</p> <ul style="list-style-type: none"> • Vision: Sierra Leone that is free of Neglected Tropical Diseases • Mission: To maintain a well-managed, integrated and sustainable NTDP that will provide quality services for the control, elimination and eradication of NTDs that are endemic in Sierra Leone through a comprehensive and consolidated approach that will include accurate mapping, treatment, prevention, surveillance and research.
<p>High-Level Targets:</p> <ul style="list-style-type: none"> • Overall: To control and eliminate Neglected Tropical diseases and significantly reduce suffering due to their chronic manifestations in Sierra Leone by 2020 • Onchocerciasis: To eliminate onchocerciasis in all 12 endemic districts with CDTI intervention by 2020 • Lymphatic filariasis: Elimination of LF as a public health problem by 2020 • SCH: To control SCH and reduce their transmission to a low level by 2020 • STH: To control STH and reduce their transmission to a minimal level • Guinea worm: To continue surveillance system of guinea worm / dracunculiasis • Human African Trypanosomiasis: To conduct assessments of HAT in districts bordering Guinea and Liberia • Buruli ulcer: To prevent disability from buruli ulcer by 2020. • Trachoma: To eliminate trachoma as blinding disease by 2020 in the country. • Leprosy: To prevent disability from leprosy by 2020
<p>Key Objectives:</p> <ul style="list-style-type: none"> • Strategic Priority 1: Strengthen government ownership, advocacy, coordination and partnerships • Strategic Priority 2: Enhance planning for results, resource mobilization and financial sustainability of national NTD programme • Strategic Priority 3: Scale-up access to interventions, treatment and system capacity building • Strategic Priority 4: Enhance NTD monitoring and evaluation, morbidity control, case management, surveillance and operations research.
<p>Description of Costs (if available):</p> <ul style="list-style-type: none"> • 5 year cost projections from 2016-2020 are approximately \$64 million dollars
<p>Health Systems Crossover</p> <ul style="list-style-type: none"> • Inadequate <i>human resources</i> to implement NTD activities/interventions continues to be a concern • Inadequate <i>financing</i> remains the primary constraint inhibiting the full implementation of the health sector annual work plans (AWP), including the NTD control programme. • The current level of public funding is about US\$ 2.9 per capita on average, which falls far below the estimated requirements. Mostly only 30% of the approved Ministry’s budget is actually disbursed • Half of the strategic priorities involve resource mobilization, increased funding to the NTD programme, as well as strengthening districts surveillance, supervision and monitoring and evaluation of NTD’s.

Mental Health
<p>Key Document and Status:</p> <ul style="list-style-type: none"> • Mental Health Policy and Strategic Plan – 2018 • Mental Health Strategic Plan 2018-2022 and Implementation and Monitoring and Evaluation Plan 2018-2020 in development
<p>Responsible Party within MoHS: Directorate of NCDs and Mental Health</p>
<p>Situation Analysis and Key Challenges:</p> <ul style="list-style-type: none"> • Statistics about mental health in Sierra Leone are limited. A WHO study conducted in the aftermath of the civil war suggested a significant burden coming out of the conflict period, with rates of “2% (50,000) for psychosis; 4% (100,000) for severe depression; 4 % (100,000) for severe substance abuse; 1% (25,000) for mentally retarded and 1% (25,000) for epilepsy.”¹⁸ More recently, research conducted in the aftermath of Ebola on both survivors and front-line health care workers suggests a significant burden of illness among these populations.¹⁹ For many years, the MoHS has only had a single psychiatrist on staff.
<p>Vision, Mission Goal:</p> <ul style="list-style-type: none"> • Vision: All people living in Sierra Leone will enjoy the best possible mental health, social and psychological wellbeing • Mission: To have available in Sierra Leone a sustainable and accessible mental health system of care and support...
<p>High-Level Targets (specific targets being developed):</p> <ul style="list-style-type: none"> • Long term Result 1: Enhanced governance and leadership for mental health services • Long term Result 2: Improved mental health service delivery • Long term Result 3: Strengthened mental health human resource capacity • Long Term Result 4: Increased use of information, evidence and research • Long term Result 5: Improved mental health medical products and technologies • Long Term Result 6: Enhanced financing for mental health services
<p>Key Objectives:</p> <ul style="list-style-type: none"> • Objective 1: Governance and Leadership: To have oversight for implementation of the Mental Health Strategic Plan and coordinate and collaborate with all relevant stakeholders. • Objective 2: Service Delivery: To deliver effective, safe, quality mental health interventions to those that need them, when and where they are needed, with minimum waste of resources. • Objective 3: Human Resources: To train and, recruit and deploy a competent and motivated mental health workforce. • Objective 4: Information, Evidence and Research: To strengthen the collection, analysis and dissemination of mental health data within the HMIS system as well as to build up mental health research to inform evidence-based mental health systems planning and programming. • Objective 5: Medical Products and Technologies: To ensure equitable access to essential mental health drugs of assured quality, safety, efficacy and cost-effectiveness; and to build up centers of excellence at regional level with state of the art and appropriate technologies available, with trained personnel able to use and maintain them • Objective 6: Mental Health Financing: To ensure financial protection for people with mental disorders and their families, through inclusion in Universal Health Coverage and other financing mechanisms.
<p>Description of Costs (if available):</p> <ul style="list-style-type: none"> • N/A
<p>Health Systems Crossover</p> <ul style="list-style-type: none"> • To ensure the mental health needs of the people of Sierra Leone are met, education and training is required, the mental health infrastructure must be expanded, and care must be decentralized. Increasing capacity must be pursued at each level of the referral system, from specialist to subspecialist, and non-specialist, ensuring that a greater range of individuals along the referral chain are capacitated to provide mental health support.

¹⁸ Mental Health Policy and Strategic Plan (DRAFT). 2017.

¹⁹ Dong Ji et al. Prevalence of psychological symptoms among Ebola survivors and healthcare workers during the 2014-2015 Ebola outbreak in Sierra Leone: a cross-sectional study. *Oncotarget*. 2017. Accessible at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5355054/>

- To strengthen the collection, analysis and dissemination of mental health data within the HMIS system as well as to build up mental health research to inform evidence-based mental health systems planning and programming

<i>Ebola Survivors</i>
Key Document and Status: N/A
Responsible Party within MoHS: Ebola Survivors Project Implementation Unit (PIU)
Situation Analysis and Key Challenges: <ul style="list-style-type: none"> • The unprecedented scale of the Ebola virus disease (EVD) outbreak that began in West Africa in 2013 has resulted in many more survivors compared to any other EVD outbreak in history. There are currently 3,466 registered EVD survivors in Sierra Leone. • Based on the current evidence base, EVD survivors frequently experience musculoskeletal, ocular, auditory, abdominal, neurological, mental health and sexual health sequelae. • Survivors also continue to face stigma in their communities, as well as challenges accessing health services. Many survivors remain highly vulnerable, given the trauma and loss of livelihoods that they, their families, and communities experienced as a result of their illness. • In November 2015, H.E. President Dr. Ernest Bai Koroma committed to ensuring free health care for EVD survivors throughout Sierra Leone.
Vision, Mission, Goal: <ul style="list-style-type: none"> • Vision: All EVD survivors can access free, comprehensive, high-quality health services that are well-informed, responsive to EVD survivor needs, non-stigmatizing, and address the risk of resurgence. • Mission: The MOHS, in collaboration with partners, will provide free, high-quality health and psychosocial services for EVD survivors through the public system, including specialty services related to EVD sequelae, and those that address the risk of resurgence.
High-Level Targets: <ul style="list-style-type: none"> • Ultimate Outcome 1: All EVD survivors nationwide are able to access to free, standard and equitable health care, BPEHS and specialty health services without stigma. • Ultimate Outcome 2: Risk of EVD resurgence is mitigated through the provision of viral persistence testing and monitoring of VP data. • Ultimate Outcome 3: SLAES is fully capacitated to provide advocacy/accountability support for survivor health care. • Ultimate Outcome 4: Survivor data collection and analysis happens regularly through MOHS system and periodically informs review of clinical guidelines and programming. • Intermediate Outcome 1: The Government will ensure availability and accessibility of free BPEHS and specialty services for EVD survivors through engagement with various MOHS Directorates, District Health Management Teams, SLAES, and NGO partners. • Intermediate Outcome 2: The Government establishes clear policies and guidelines to govern free health care for survivors, which are clearly communicated to MOHS Directorates, DHMTs, and health workers.
Key Objectives: <ul style="list-style-type: none"> • Strategic Objective 1: Provide comprehensive, high-quality health and psychosocial services to all EVD survivors • Strategic Objective 2: Engage EVD survivor community in accountability and advocacy for survivor care • Strategic Objective 3: Utilize survivor data to adapt policy, improve services for EVD survivors, and address risk of resurgence
Description of Costs (if available): <ul style="list-style-type: none"> • N/A
Health Systems Crossover <ul style="list-style-type: none"> • Ebola survivors require specialized care for some of their follow-on ailments after recovery (e.g., eye care issues). In order to serve these survivors, the MoHS has to provide trained human resources and the specific medical supplies required to serve this population.

National Eye Health Programme
Key Document and Status: National Eye Health Policy – 2017 In development
Responsible Party within MoHS: National Eye Health Programme
Situation Analysis and Key Challenges: <ul style="list-style-type: none"> • According to the Rapid Assessment of Avoidable Blindness (RAAB) of 2010, the prevalence of blindness (presenting visual acuity (VA) VA<3/60 in the better eye) was 5.9% in the population over the age of 50 years. Cataract was the major cause of blindness and Severe Visual Impairment followed by glaucoma then other posterior segment disease and non-trachomatous corneal opacities. • Of all blindness in Sierra Leone, 91.5% is avoidable and 58.2% is treatable. Refractive errors are the most important cause of Moderate Visual Impairment followed by cataract. Four-fifths of all persons with a refractive error do not have spectacles. Uncorrected presbyopia is 94.4%. The study found that the main barriers that affect access to services were cost of surgery, need for surgery not felt, lack of awareness about the disease and its treatment, fear of surgery and traditional beliefs. • Other causes of ocular morbidity include allergies, dry eye, trauma and infections. Although most of these are not blinding, they occur commonly and have a significant effect on productivity.
Vision, Mission Goal: <ul style="list-style-type: none"> • Vision: The highest standard of eye health for all people in Sierra Leone. • Mission Goal: Reduce burden of eye diseases through comprehensive and quality eye health service that is accessible and affordable to all people in Sierra Leone
High-Level Targets: General Objective: Sustainable, comprehensive and quality eye health service that is accessible and affordable to all people in Sierra Leone
Key Objectives: <ul style="list-style-type: none"> • Objective 1: Governance and Leadership: To strengthen effective leadership and coordination of eye health service delivery • Objective 2: Service Delivery: To promote access to comprehensive, integrated, affordable and quality, promotive, preventive, curative and rehabilitative eye health services at community, school, workplace and health facility • Objective 3: Human Resources: To promote Human Resource for eye Health that is skilled, motivated and equitably distributed • Objective 4: Information, Evidence and Research: To promote use of management information systems and research for evidence-based planning, advocacy and improvement of quality and access to eye health services. • Objective 5: Medical Products and Technologies: To ensure availability of appropriate infrastructure, functional equipment, essential medicines, diagnostics, assistive devices and health technologies at all levels • Objective 6: To ensure access to affordable quality eye care services for the people of Sierra Leone.
Description of Costs (if available): <ul style="list-style-type: none"> • N/A
Health Systems Crossover <ul style="list-style-type: none"> • For sustainable, comprehensive and quality eye health service that is accessible and affordable to all people in Sierra Leone we need to strengthen integration of eye health services in the mainstream health service from national level to the community level. In so doing the programme will address National and Global agenda • Inadequate eye health personnel to provide eye care services throughout the country there is a need for training of personnel • Inadequate funding for eye health programme, therefore there is a need to facilitate robust funding for eye health care in Sierra Leone

Please note: Drafts of Dentistry and Emergency Service strategies/policies not available at the time of HSSP development – these priorities will need to be reflected during the next periodic health sector review.

<i>Infection, Prevention and Control</i>
Key Document and Status: <ul style="list-style-type: none"> National Infection Prevention and Control Action Plan – 2016 – 2019 Launched 2016
Responsible Party within MoHS: National Infection and Prevention Control Unit
Situation Analysis and Key Challenges: <ul style="list-style-type: none"> Healthcare associated Infections are a significant threat to patient and healthcare worker safety in Sierra Leone. The IPC Unit of the MoHS is working to establish a culture of infection and prevention control in healthcare facilities.
Vision, Mission Goal: <ul style="list-style-type: none"> Vision: Infection prevention and control (IPC) is part of a comprehensive approach to improve health outcomes. Mission: The development of a national IPC Action Plan 2016-2019 will enable the equipping of health facilities, open up conditions for the mobilization of resources required for the implementation of standard precautions and transmission-based precautions to prevent and/or to contain healthcare-associated infections. The patient and staff safety will be improved. Goal: Establishment of an IPC policy and strategy provides a framework to develop and implement guidelines and standard operating procedures (SOPs) in order to establish a culture of safety in healthcare facilities.
Key Objectives: <ul style="list-style-type: none"> Ensure compliance on Hand Hygiene practice in all tertiary and secondary HCF by 2018 Ensure compliance on Hand Hygiene practice in 80% primary HCF by 2018 Institutionalize the local production of ABHR in all District Hospitals by 2018 Ensure that aseptic procedures are followed for all procedures in all HCF by 2017 Establish a HAI/AMR surveillance system in all hospitals in collaboration with Lab and Surveillance programs by end of 2018. Ensure Environmental Health Care Management practices are instituted in all Healthcare Facilities by 2018 Ensure Provision of environmental cleaning equipment, supplies and consumables in all Health facilities at all times by 2018 Ensure effective decontamination of reusable medical devices in all HCF by 2017 and at all times thereafter Ensure effective medical waste management in health facilities as per policy guideline by 2018 Ensure Proper and effective management of linens used in health care settings at all times Ensure that all Healthcare facilities have a functional screening area by end of 2017 Ensure early detection and safe isolation of suspected cases of infectious diseases in all HCF by 2017 Establish healthcare worker occupational infection prevention control program in all health facilities by end of 2017 Baseline assessment of community behavior and practices Engage the community on standard IPC Practices Regular monitoring of IPC behavior and practices in the community Develop a national IPC strategy to improve IPC practices for traditional healers Patient and caregiver engagement in HCFs Establish Technical Working Group (TWG) focused on M&E activities Review/develop the IPC/WASH M&E tools Establishing a well-developed data management system Ensure a well-established IPC Quality Improvement (QI) / Quality assurance (QA) system Establish a strategy for data dissemination and use of results Develop system for linking the national M&E system to private HCF
Description of Costs (if available): <ul style="list-style-type: none"> The total plan is estimated to cost \$6M USD over three years

<i>Surgery, Obstetrics and Anaesthesia</i>
Key Document and Status: <ul style="list-style-type: none"> • Sierra Leone National Surgical, Obstetrics and Anaesthesia Plan • Document being developed
Responsible Party within MoHS: Directorate of Hospitals and Laboratory Services
Situation Analysis and Key Challenges: <ul style="list-style-type: none"> • Sierra Leone has a massive unmet need for safe surgery and anaesthesia, including obstetric surgery. • There is inadequate infrastructure and supplies to meet this need. • There is a critical shortage of trained, motivated workforce and existing staff are unevenly distributed. • There is insufficient collection and use of data on surgical care, including both routine data and research efforts. • The high cost of care is a major barrier to accessing surgical care. • Many communities are unaware of how to prevent surgical disease and when and where to seek care.
Vision, Mission, Goal: <ul style="list-style-type: none"> • Vision: All Sierra Leoneans have access to safe, affordable surgical and anaesthesia care when needed • Mission: Scaling up of quality training, ensuring availability of equipment and supplies, decreasing financial barriers to surgery, and improving quality of care • Goal: Prevent and reduce surgical and obstetric morbidity and mortality in Sierra Leone
High-Level Targets: <ul style="list-style-type: none"> • Overall Objective: To increase access to safe, affordable surgical, obstetric, and anaesthesia care when needed
Key Objectives: <ul style="list-style-type: none"> • Strategic Objective 1: Surgery, obstetric and anaesthesia services are delivered safely and effectively • Strategic Objective 2: There is adequate infrastructure to deliver safe surgery, obstetrics and anaesthesia • Strategic Objective 3: There is a qualified, motivated and contextually appropriate surgical, obstetric, anaesthetic and nursing workforce is in place in all district, regional, and tertiary hospitals • Strategic Objective 4: Surgical data is collected and used • Strategic Objective 5: Surgical, obstetric and anaesthesia services are affordable and sustainably financed • Strategic Objective 6: Communities are aware and informed about how to avoid surgical disease and when and where to seek care
Description of Costs (if available): <ul style="list-style-type: none"> • No formal costing has been performed for the plan. Much of the funding is expected to come from external sources. • There is significant overlap with various existing strategies including human resources, supply chain, and information systems.
Health Systems Crossover <ul style="list-style-type: none"> • The plan has been formulated in alignment with existing policy on HIV, TB, Malaria, pharmaceutical procurement and management, safe blood practice, IPC, maternal and child health, essential healthcare and human resources for health. • Surgery, obstetrics and anaesthesia care has a particularly great impact on maternal and child health; improved surgery, obstetrics and anaesthesia care are critically needed to decrease the high maternal and neonatal death rates in Sierra Leone. • Implementing the National Surgical, Obstetrics and Anaesthesia Plan requires system-wide strengthening, including services such as functional blood banks, facility equipment and ambulance services, which would benefit all hospital domains. • Surgical indicators are to be included in health information management tools such as the DHS and the DHIS • Existing initiatives to expand healthcare coverage, improve hospital management, and update standard operating procedures are important components of the plan. • Efforts to scale up surgical workforce are embedded in the HRH plan.

CHAPTER 3: HUMAN RESOURCES FOR HEALTH

A. Relevant Documents

Strategy or Policy	Responsible Entity
<ul style="list-style-type: none"> • Human Resources for Health Strategic Plan – 2017 – 2021 Launched • Human Resources for Health Policy – 2017 Launched 	Directorate of Human Resources for Health
<ul style="list-style-type: none"> • Community Health Worker Strategic Plan Under development • Community Health Worker Policy – 2016 – 2020 Launched 	Directorate of Primary Healthcare
<ul style="list-style-type: none"> • Nursing and Midwifery Strategy Under development • Nursing and Midwifery Policy Under development 	Directorate of Nursing and Midwifery Services

B. Vision and Mission

The following visions and missions for HRH and CHWs respectively are drawn from the existing HRH and CHW documents that have been validated and launched. It is presumed that the Nursing and Midwifery Policy and Strategy will also contain a vision and mission, once completed.

	Vision	Mission
HRH	A resilient health workforce that is delivering cost-effective, evidence-based and high-quality health care services that are equitable and accessible for the population of Sierra Leone by 2025.	To plan, produce, deploy, and maintain a resilient, highly motivated health workforce that can contribute to national socioeconomic development by ensuring equitable, affordable and high-quality health care services for the population of Sierra Leone.
CHWs	To support a functional CHW programme that is part of a resilient national health system. The Programme aims to provide efficient, basic, and high-quality services that are accessible to everybody, especially people living in hard-to-reach areas.	CHWs contribute to the Agenda for Prosperity: Road to Middle-Income Status (2013–2018) and socio-economic development by promoting access to high-quality health care, including reproductive health care and nutrition services, for the population of Sierra Leone.

C. Current Status and Situation Analysis

Sierra Leone faces stark and continuing challenges in this pillar of the health system, with gaps in resources and capacity clearly evident across the public sector workforce at all levels. These gaps are especially pronounced in higher-skilled cadres, such as medical specialists and officers, midwives and highly skilled generalist and specialist nurses. Fortunately, the current challenges surrounding HRH in Sierra Leone – and the potential impact of increasing both the quantity *and* quality of health workers – have received significant new attention and focus in recent years. This new attention began in part with the FHCI, launched in 2010, which injected significant new personnel into the workforce. However, this

initial forward movement was violently halted as Ebola wrought havoc on the health system, claiming the lives of 257 health workers.²⁰

Since then, the MoHS has invested significant time and effort into supporting its HRH ecosystem in the aftermath of Ebola, both to rebuild what has been lost as well as to guard against any future crises. Recent efforts have included a number of investments in the Directorate for HRH in the MoHS; initial conversations within the Directorate of Nursing and Midwifery Services to develop a policy and strategy specific to those cadres; the launch of the CHW Policy (2016-2021) and roll out of the accompanying national programme, where over 15,000 CHWs serve as a platform to deliver information and high impact and cost-effective reproductive, maternal, newborn and adolescent health and nutrition interventions at the community and household levels; and the launch of new entities to improve medical training in the country. These efforts have brought a refreshed energy to the space. However, there are still a number of interlocking challenges that continue to compound the gaps in the HRH ecosystem and slow progress towards a resilient health workforce:

- **Health Workforce Education:** At present, 25 public and private training institutions across Sierra Leone offer 56 different education programs, ranging from certificate to Master's level. Despite significant increases in staffing levels since the advent of the FHCI in 2010, Sierra Leone at present does not have sufficient health workers to meet the staffing norms defined in the Basic Package of Essential Health Services 2015-2020. There is no nationally coordinated pre-service training plan accepted by MoHS, MEST and training institutions.
- **Health Workforce Deployment:** The deployment of health workers is considerably skewed, with more than half of the entire workforce is posted between Western Area and Bo. This differential is not attributable to relative populations between districts.
- **Health Workforce Management of Salaried and Unsalariated Staff:** Management of the 10,000-strong salaried workforce – all civil servants – remains centralized within the MoHS, which creates a series of administrative challenges when many HRH decisions are made at the district level. However, the biggest challenge in this area is the unsalaried health workers – both clinical and non-clinical workers, not on the civil service payroll, who are currently working in health facilities around the country.
- **Health Workforce Regulation:** As noted above, Sierra Leone presently has three regulatory bodies – the Sierra Leone Medical and Dental Council, the Sierra Leone Nurses and Midwives Board, and the Sierra Leone Pharmacy Board. All three are under-resourced, with limited ability to follow up on the licensing and supervision of the cadre under their purview. Planned legislation may help improve the regulatory environment.
- **Health Workforce Financing:** The MoHS portion of the civil service wage bill is USD \$20.5M, or roughly 9% of the total cost of the civil service. Donors have historically supported portions of the wage bill, though those commitments have come to an end and there are no known external funding commitments planned for the workforce in the near future. A lack of a clear and secure multi-year budget ceiling through MOFED hampers the MoHS' ability to plan.

D. Objectives and Actions

The following draws from the current Objectives and Targets that have been validated and launched through the HRH Strategy. Please note that the text below is drawn directly from the Executive Summary of the HRH Strategy document. Similar Objectives and Actions for the CHW program are

²⁰Directorate for Human Resources for Health, MoHS

presently under development and these priorities will need to be reflected during the next periodic health sector review.

- **Strategic Objective 1: Enhance evidence-based HRH decision-making for the rational management and financing of health workers:** Under this strategic objective, MoHS aims to improve the collection, quality, use, and availability of health workforce data to ensure that evidence- and needs-based decisions are made by GoSL. Fundamental to this strategic objective are the improvement of existing and the introduction of new MoHS information- and evidence-based systems including the Human Resources Information System (iHRIS) and the District Health Information System (DHIS2).
- **Strategic Objective 2: Improve HRH production to address national health needs and meet health personnel requirements:** Under this strategic objective, MoHS aims to improve the quality, quantity and mix of its health workers. Immediate plans include investments in increasing production of professionals in midwifery and higher nursing along with strengthening the capacity of CHWs. During 2017, MoHS will also complement these investments with planning to determine how community-level cadres should evolve to respond to future primary care needs, which will then contribute to a long-term training plan. As the strategy development prioritised quality of training over quantity, strengthening clinical components of training will be a key focus. This will be a challenging endeavor, as the MoHS is not in control of many of the training institutions – some of which are managed by MEST and some of which are managed privately.
- **Strategic Objective 3: Strengthen governance, leadership, and management for HRH:** Under this strategic objective, MoHS aims to strengthen its capacity to effectively plan and manage the national health workforce at the central and, especially, at the district level. Doing so requires investments in the leadership and management capacity at all levels of MoHS and in public health facilities. The MoHS will need to ensure staff are motivated and retained (especially in rural areas), and that HR professionals within MoHS the tools and knowledge necessary to make evidence-based decisions about the workforce. Additionally, critical investments will be made in the regulatory bodies and agencies that ensure the quality of health workforce training and service provision. This will include ensuring clearly developed standards of practice as well as regular regulatory audits.
- **Strategic Objective 4: Establish and promote partnerships among public, private and not-for-profit stakeholders:** Under this strategic objective, MoHS aims to establish the cooperation and partnership from all sectors necessary to achieve the goal of this HRH Strategy. Across the government and regulatory agencies, inter-ministerial coordination is necessary to plan for, develop, and finance the national workforce. Within MoHS, effective, community-based participation is necessary to improve health worker accountability and management. Partnerships with private-sector, non-governmental, and faith-based organizations in service delivery, education, and technology is paramount to resourcing and implementing the HRH Strategy successfully.
- **Strategic Objective 5: Support resource mobilization and advocacy efforts to ensure the implementation of the HRH Policy and Strategy:** Under this strategic objective, MoHS aims to mobilize the resources necessary to fully implement the HRH Strategy. Sierra Leone requires additional investment to develop, manage, and maintain its health workforce to achieve the objectives in the HRH Strategy. MoHS will work with development partners to integrate improved data collection and analysis with budget development and prioritization of funding.

E. Expected Outputs and Outcomes

A full list of outputs and outcomes can be found in the M&E Annex, which collates all existing M&E frameworks from the various plans that have been recently developed. Selected indicators include:

- **Ultimate Outcome 1:** Targeted improvements in the coverage and quality of services delivered by health workers in Sierra Leone's public sector health workforce
- **Ultimate Outcome 2:** Targeted increases in the number of highly-skilled health workers in Sierra Leone's public sector health workforce
- **Intermediate Outcome 1:** The Government pursues knowledge-based, results-focused strategies and actions that improve the absorption, distribution, management, performance and retention of the public sector health workforce
- **Intermediate Outcome 2:** The Government effectively plans the financing of the public sector health workforce based on evidence of needs and towards long-term sustainability
- **Intermediate Outcome 3:** Increased production of targeted clinical and non-clinical cadres. Improved quality of training in targeted clinical and non-clinical health professional training programs, pre-service as well as in-service

CHAPTER 4: HEALTH FINANCING

*****Please note: As the Health Financing Strategy is still in its early planning stages, this section of the HSSP will merely set out the current status and situation analysis in this area, in order to inform the objectives and activities that will be developed as part of the Health Financing Strategy development. This section will be updated and brought in line with the final version of the Health Financing Strategy at the 1-year review of the HSSP.*****

A. Relevant Documents

Strategy or Policy	Responsible Entity
<ul style="list-style-type: none">National Health Financing Strategy Planned; Not yet Started	Directorate of Policy, Planning and Information

B. Current Status and Situation Analysis

Overview

While there have been significant reforms in the health sector in Sierra Leone since 2010, efficient financing of the various components of the health system remains a key challenge. The National Health Accounts (NHA) 2013 estimates the total health expenditure in Sierra Leone at approximately USD \$590 million. This equates to a per capita expenditure of USD \$95 (Le 400,000²¹). However, the NHA also reported that almost 61% of the total health expenditure was composed of Out-of-Pocket expenditures(OOP), down from a high of 83% reported by the by the NHA in 2008. During the same period, external resources for health as a percentage of total health expenditure have also increased steadily from a low of 12% in 2007 to 25 % in 2013. Allocations to health as a proportion of total Government expenditure continues to remain below the 15% pledge made in the Abuja Declaration. The actual expenditure on health in 2016 was estimated to be at 6% of total government expenditure.²²

The Free Health Care Initiative (FHCI) has been one of the most significant reforms in the sector. The FHCI aimed to reduce Out-of-Pocket payments on health for pregnant and lactating mothers and children under 5 years of age. Official FHCI expenditures were estimated to be USD \$97 million in 2015 and were projected to rise to USD \$136 million in 2025. This initiative is heavily donor-dependent, with 80% of financing coming from external sources in 2015.²³ Salaries for health workers were doubled with the introduction of FHC, and the additional salary costs were initially carried by donors. In 2016, Government paid the whole wage bill, while donors funded a majority of drugs procurement for the program – those two costs being the two main cost drivers of the FHCI. A comparison with its neighboring countries reveals that Sierra Leone’s spending on health is higher than other countries in the region, largely driven by high out-of-pocket expenditures.²⁴

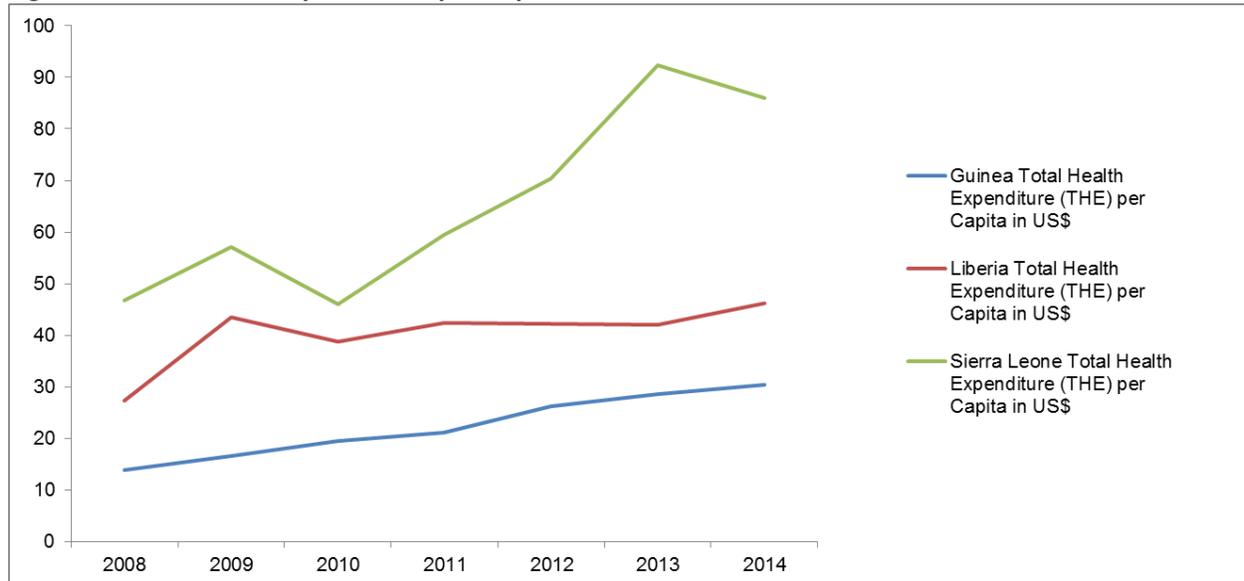
²¹ At 2013 exchange rates

²² Total GoSL expenditure for 2016 provided in Budget Profile 2017; expenditure on health based on expenditure reports of MoHS, transfers to Local Councils, Public Investments and Payroll expenditure

²³ OPM Evaluation of FHCI

²⁴ World Health Organization Global Health Expenditure database

Figure 5: Total Health Expenditures per Capita in USD



As mentioned above, this higher spending is not reflected in commensurate gains in health outcomes. Sierra Leone's Infant Mortality Rate was 87 per 1,000 live births as compared to 61 in Guinea and 53 in Liberia for the year 2015. In the case of Maternal Mortality Ratio in the same year, Sierra Leone reported 1,360 deaths per 100,000 live births as compared to 679 in Guinea and 725 in Liberia.²⁵

This can be partly linked to the disruption to the health financing landscape due to the Ebola epidemic, both in the execution of planned activities as well as to the general health of the economy. This challenge has been compounded by weakened mineral revenues in line with global trends. While the country embarked on a significant period of rebuilding since the Ebola epidemic, a number of systemic gaps contribute to challenges in absorption and effective utilization of financing for healthcare. While the challenges in resource availability and the need for increased government spending have historically featured in discussions on the financing of health, there is a clear need to improve efficiencies in deploying resources for health at all levels. This renewed focus is reflected in the MoHS' commitment to developing a national health financing strategy.

Institutional Arrangements

The **Directorate of Financial Resources (DFR)** is the primary financial management agency of the Ministry of Health and Sanitation (MoHS). Budgeting and expenditure of Government of Sierra Leone funds on the programs and directorates of the MoHS are administrated by the DFR. In addition to the DFR, the MoHS has also set up the **Integrated Health Projects Administrative Unit (IHPAU)**, which provides fiduciary oversight of donor supported projects.

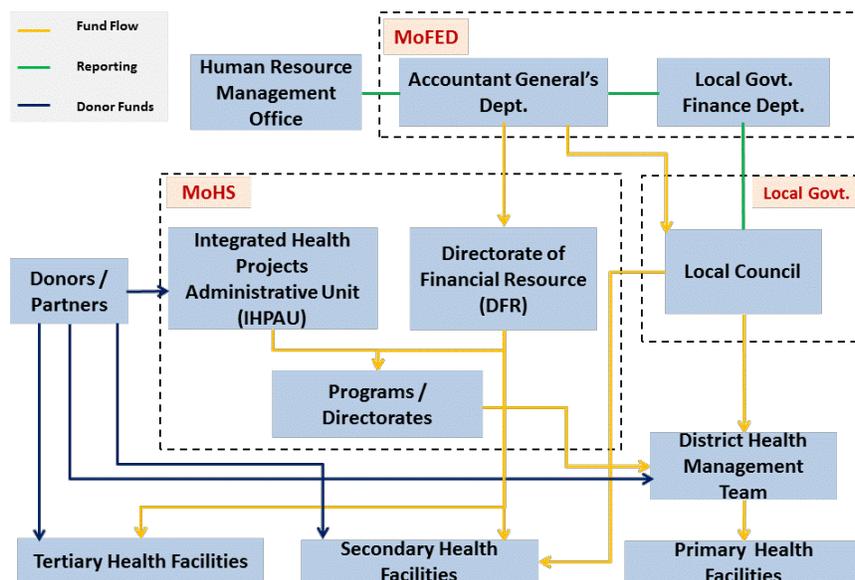
In line with the decentralization policy adopted after the enactment of the Local Government Act 2004, Primary and Secondary healthcare services are devolved functions in Sierra Leone. Government funding

²⁵ <http://data.worldbank.org/indicator/SP.DYN.IMRT.IN> Note: data differs slightly from NHA estimates due to different methodology

for these services are transferred directly to the local council primary and secondary healthcare accounts by the Ministry of Finance and Economic Development (MoFED). These transfers are administered centrally by the **Local Government Finance Department** of MoFED. In the case of Primary Health care, the District Health management Teams are the technical wing that accesses funds available to local councils and support the operations of Primary Health Units. In the case of Secondary Health, hospitals operate as separate accounting units and the Medical Superintendents of secondary hospitals access funds earmarked for secondary health for the respective local council. Tertiary Hospitals receive funding directly from the allocations of the MoHS²⁶. It may also be noted that DHMTs, as well as Secondary and Tertiary Health care facilities are reported to receive funding from the central MoHS pool and from donors through accounts held separately from those associated with Local Councils.

Contrary to the decentralized program funding, the wage bill for health workers is processed monthly by the **Human Resources Management Office** which processes pay roll for all civil servants in Sierra Leone. Disbursements of approved budgetary allocations are done by the **Accountant General's Department** after receiving clearance from the **Budget Bureau** in case of recurrent expenditures, the **Public Investment Program (PIP)**, in case of capital expenditures and HRMO in case of salary payments. During all disbursements, transfers to Ministries Departments and Agencies (MDAs) including those related to health, are made from the Consolidated Revenue Fund (CRF) held at the **Bank of Sierra Leone (BoSL)** where all GoSL revenue from taxation and other sources are pooled.

Figure 6: Map of Institutional Relationships for Health Financing



Performance Based Financing (PBF)

The PBF scheme was introduced nationwide in April 2011, a year after the introduction of Free Health Care Initiative (FHCI). The FHCI Initiative tackled the issue of user fees in accessing services, however, during the first year of the initiative's implementation it became evident that supply (provision of health care services) did not cope with the increased demand (more users wanting to access services). In an attempt to increase quality as well as efficiency of service delivery and also tackling persisting informal

²⁶ For the period 2010-2013 Tertiary Hospitals received funding through Local Council budgets

fees at facility level, the PBF scheme was introduced at all 1200 public PHUs²⁷ with six quantity indicators focusing on Reproductive and Child Health (RCH) services and ten quality indicators. A year later, the two national referral hospitals for RCH, Ola During Children Hospital and Princess Christian Maternity Hospital were added to the scheme. They are evaluated and paid based on quality criteria.

The scheme was managed by the PBF Technical Team, supported by the Health Financing Unit of the Ministry of Health and Sanitation. The verification teams in the districts were led by the District Health Management Teams and supervision and verification were done jointly with the local councils. Between 2011 and 2016, USD 15 million were disbursed to facilities and DHMTs. The PBF scheme in Sierra Leone pays about half a dollar per year per capita, or about LE 3600. This is quite low compared with other schemes in Sub-Saharan Africa. Furthermore, the average facility received USD 2100 per year, where each health care worker received between USD 20-100 extra per month from the PBF scheme²⁸. The scheme came to a preliminary end in 2016, while the MoHS and the World Bank (the funder of the scheme) is reviewing its success and will decide about the future implementation. Two external verifications completed in 2014 and 2016 respectively have found similar success stories and challenges, summarized in the below table:

Success	Challenge
Potential increase of workers' motivation	Weak verification mechanisms and data management
Helped facilities secure basic infrastructure, equipment, consumables and drugs during stock outs	Lack of financial management skills both at facility level (records management) and central level (payment delays)
Provided some level of flexibility to facilities	Weak involvement of communities
Seemingly high patient satisfaction	Unclear roles and responsibilities of the local councils (the purchaser)
Contributed to improved service delivery	Payments not necessary linked to performance

Sierra Leone Social Health Insurance (SLeSHI)

In March 2017, the Government of Sierra Leone officially launched a mandatory and universal Social Health Insurance (SLeSHI) scheme. SLeSHI is envisaged as an autonomous corporate body with legal, administrative and financial autonomy. The benefits package under SLeSHI includes primary health services²⁹. It is proposed that the scheme is funded by contributions by formal and informal sector employees as well as ear-marked taxes. The contribution rates being currently discussed are 6% of salaries from formal sector employees, and LE 15,000 per month for informal sector employees. The contribution from the informal sector was determined based on the findings of a willingness to pay survey. It is also proposed that contributions from the Goods and Services taxes, a percentage of MoHS budget, registration fee of vehicles, and contributions from Social Safety Net Funds be used to fund this scheme. The next steps planned in 2017 for establishing the scheme include the passing of the SLeSHI Act in 2017 and the continued sensitization of key stakeholders nationwide.

²⁷ This also includes 33 not-for-profit private health facilities that are implementing the FHC initiative.

²⁸ This depends on the size of the facility and the rank of the employee. Field evidence suggests that the PBF money makes up 10-30% of the total health worker's salary. This has been further confirmed by Witter, S., Bertone, M., Wurie, H., Edem-Hotah, J., & Samai, M. (2014); in *Health worker incentives in Sierra Leone: survey report*. ReBUILD.

²⁹ The benefits package has not been finalized in June 2017 and might change before SLeSHI is introduced.

CHAPTER 5: MEDICAL PRODUCTS AND HEALTH TECHNOLOGIES

A. Relevant Documents

Strategy or Policy	Responsible Entity
<ul style="list-style-type: none"> National Medical Supplies Agency Operational Plan – 2017-2018 	NMSA Management Team <i>(pending recruitment)</i>
<ul style="list-style-type: none"> National Health Laboratory Strategic Plan –2016 – 2020 	Directorate of Hospitals and Laboratory Services

B. Mission and Vision

	Supply Chain	Laboratory Services
Vision	To ensure the transparent, cost-effective and timely availability of medical supplies to every health facility funded by the GoSL	To provide Sierra Leone with a quality and appropriate laboratory service that is accessible and affordable to all using a systems approach.
Mission	To establish the processes, systems and infrastructure in order to effectively manage the health sector supply chain for the MoHS.	To establish an integrated functional laboratory system that will provide quality service delivery and support accurate diagnoses, treatment, prevention, surveillance, research and forensic services.

C. Current Status and Situation Analysis

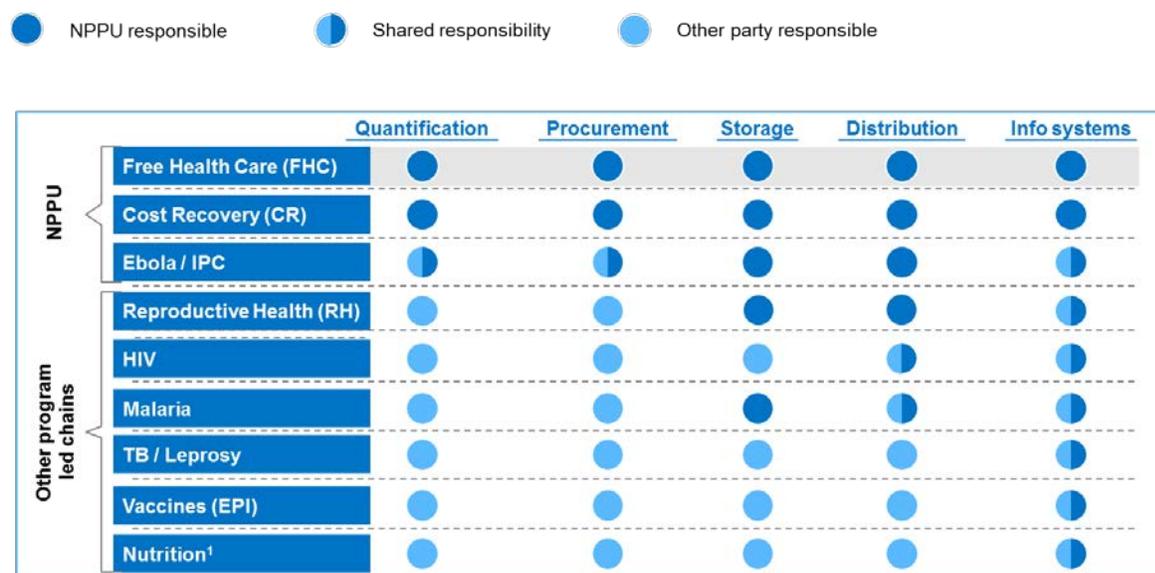
Health Sector Supply Chain

In March 2016, the State House of Sierra Leone issued a press release announcing the complete restructuring of the National Pharmaceutical Procurement Unit (NPPU). The NPPU was the institution mandated by the MoHS to be responsible for the management of medical supplies for all public health facilities, and particularly supplies related to the Free Healthcare Initiative (FHC). This includes not only drugs and consumables, but also medical equipment that is essential to the delivery of quality health services, such as X-ray and ultrasound equipment where relevant. However, NPPU had been plagued since its inception in 2012 by a series of financial and operational challenges. While NPPU had plans to try and integrate the multiple health sector supply chains –which currently run in parallel to each other (see figure below) – a lack of financing, capacity and government buy-in prevented the institution from moving forward with these plans.

However, given the critical nature of the supply chain to the provision of public health services, including all of the service delivery areas articulated above, the decision was taken to launch a new health sector supply chain entity – the National Medical Supplies Agency (NMSA) – that could take over the mandate of the NPPU. The development of this agency has now gone through two phases, the most recent of which has focused on executing initial governance-related reforms while also further developing recommendations. This has included the recent passage of a new Act of Parliament in August 2017; the development of a new board structure; preparations for the recruitment of a new management team; planning for the financing of the new agency; and the development of a 2-year operational plan that can

be used to guide the Agency through its initial start-up period. The operational plan guides the objectives and activities in this section.

Figure 7: Supply Chain Responsibilities Across MoHS Directorates and Programmes



Health Sector Laboratory Services

Laboratory services play a critical role in health service delivery, disease surveillance and epidemic preparedness. A previous 2010 – 2015 strategic plan brought some successes to the space, including improvements in laboratory staff training and the establishment of the Central Public Health Reference Laboratory. However, the plan was interrupted by both a 2012 cholera outbreak and the 2014/2015 Ebola outbreak, and the current laboratory system in Sierra Leone remains unable to deliver on its most critical functions; to meet the laboratory capacity outlined as essential in the BPEHS; or to meet the obligations as outlined under the Global Health Security Agenda, International Health Regulations and ECOWAS regulations.

In response to this challenge, the MoHS – and in particular the Directorate of Hospitals and Laboratory Service – recently committed to develop a series of national health laboratory politics as well as a new multi-year strategic plan stretching from 2016 - 2020, which outlines action across ten key areas: governance; HR planning, development and management; infrastructure and equipment; laboratory services support systems; bio risk management; information management; emergency preparedness and response; research, development and ethics; partnerships and linkages; and total quality management systems. The strategy aims to improve laboratory services across all four tiers of the system in Sierra Leone – beginning primarily at the primary healthcare level with CHCs; at secondary hospitals; at regional and referral hospitals; and finally within Sierra Leone’s public health laboratories.

Blood Services

There is not a national plan for blood services at present. Availability of blood and transfusion services remains poor across the country, and the national blood services program remains under-resourced. The last national plan for blood services expired in 2014.

D. Objectives, Actions and Targets

The following draws from the draft NMSA Operational plan 2017 – 2018 and the draft National Laboratory Strategic Plan 2016 – 2020. Please note that some text below is drawn directly from the objectives and activities outlined in these documents.

Supply Chain

- **Objective 1 (Governance):** NMSA governance provides the guidance and accountability the agency needs to become highly functioning and transparent; the NMSA's business is conducted and shared in a transparent manner.
- **Objective 2 (National Policies):** The full suite of policy documents relating to drugs and medical supplies will be revised to reflect the epidemiology of Sierra Leone as well as current international recommendations; this will occur with the full participation and agreement of all relevant stakeholders. The policies to be revised include the Standard Treatment Guidelines, the National Formulary, and the Essential Medicines List.
- **Objective 3 (Quantification):** The quantification process is clearly defined in terms of activities and timelines, includes explicitly defined roles for select relevant stakeholders, and is agreed and signed off by all parties. The official quantification is the basis for the vast majority of NMSA's procurements, with few exceptions. The process is based on an improved set of consumption and epidemiological data.³⁰
- **Objective 4 (Procurement):** The NMSA will develop a strong capacity in procurement, grounded on set of regulations which have been agreed by all stakeholders as reflecting the best international practice as well as the local context. The procurement process will have adequate oversight by relevant stakeholders. The procurement department will ably manage all procurement using government funds, as well as a portion of donor procurement as agreed upon by the development partners when accountability targets are met. Any NMSA procurement will be fully harmonized with donor procurements, and vice versa.
- **Objective 5 (Central Warehousing and Operations):** There will be a purpose-built national warehouse for the public sector supply chain, with adequate capacity for FHC drugs and other vertical programs at the outset, with a view to integrating other vertical programs over time. The warehouse will operate efficiently and effectively, with centralized picking and packing for the facility level. The management of the warehouse will adhere to the highest standards of good warehousing practice to ensure the suitable storage and security of commodities.
- **Objective 6 (District Level Warehousing and Operations):** District Medical Stores (DMS) staff will be partners with NMSA in ensuring a sufficient and regular supply of commodities to the facilities under their purview.
- **Objective 7 (Distribution and Reverse Logistics):** Distribution will be managed efficiently and consistently. Deliveries will occur with a frequency that meets facilities' needs, but is also cost-effective. Facilities will have a clear expectation for when distributions are going to take place, and will verify that deliveries have occurred and were complete. A reverse logistics system will be in place to manage return and destruction of expired or spoiled drugs.
- **Objective 8 (Ordering and Allocation):** Facilities receive allocations of commodities that are aligned to the needs of their patients. Any significant over- and under-stocking are reduced and eliminated over time. Facility staff believe that the allocations they receive are responsive to their needs.

³⁰Improvements in epidemiological data are subject to improvements within the broader health sector, and improvements in consumption data will be addressed in the sections covering Data and Allocation / Ordering.

- **Objective 9 (Data):** Data on drug consumption and stock levels is accurate and accessible in a timely manner. Epidemiological data is improved and maintained at high quality. Data is presented in a user-friendly manner, and is widely used by MoHS staff at central and district levels as well as partners.
- **Objective 10 (Stock Security):** High levels of security are maintained for stock throughout the system. If any issues arise relating to stock security, responsibility can be traced to the accountable party. A high baseline level of security and assurance will be required to obtain donor support for the institution.
- **Objective 11 (Financing):** Funding commitments are made well in advance of when disbursements are needed, and disbursements are made on schedule. Over time, allocations of funding from the GoSL constitute an increasing part of the funding pool; and the NMSA begins to generate funds for its own operations.
- **Objective 12 (Financial Management, Internal Audit and Administration):** NMSA financial management, HR management and internal audit processes are effective, transparent and adhere to international best practice. A high baseline level of financial management and audit practice will be required to obtain any donor support for the institution.
- **Objective 13 (Transparency and Accountability):** All partners have a high level of trust in the effectiveness of the system and key information is regularly shared with all parties. Stakeholders at facility, district, and central level are held accountable for maintaining high levels of security and preventing theft. A high baseline level of transparency and accountability will be required to obtain donor support for the institution.

Laboratory Services

- **Objective 1 (Governance):** To strengthen the laboratory organizational and management structures to provide oversight / coordination of laboratory services throughout all the levels of health care by end 2020.
- **Objective 2 (Governance):** To provide a policy and legal framework for proper regulation, training, laboratory practice and observance of professional ethics in laboratory practice by end 2020.
- **Objective 3 (Governance):** To strengthen community awareness of ethics for laboratory professionals and increase demand by service users and providers at all levels by 2017
- **Objective 4 (Human Resources Development):** To meet the minimum qualified laboratory personnel levels to support the delivery of a comprehensive laboratory package at each level of health care by end 2020.
- **Objective 5 (Infrastructure):** To provide adequate laboratory space appropriate for each level for effective service delivery by end 2020
- **Objective 6 (Infrastructure):** To provide technical expertise that will align international (regional) tools and documents of equipment requirements appropriate to support the BPEHS
- **Objective 7 (Services and Support Systems):** To provide laboratory services appropriate to each level of the health care system within the defined laboratory package by end 2020.
- **Objective 8 (Services and Support Systems):** To provide all government medical labs with equipment, and assure availability of commodities for efficient service delivery by end 2020.
- **Objective 9 (Services and Support Systems):** To provide all government medical laboratories with complimentary supplies and consumables for efficient service delivery by end 2020.
- **Objective 10 (Biorisks, Biosafety, Biosecurity, Biobanking):** To support all laboratories to implement the laboratory bio-safety policy and adhere to safety guidelines by end 2018

- **Objective 11 (Information Management):** To establish a laboratory information and management system that is integrated into the national health management information system
- **Objective 12 (Emergency Preparedness):** To fully implement the IDSR strategy by 2020
- **Objective 13 (Research, Development, Ethics):** To strengthen operational research technical capacity to enhance laboratory services in Sierra Leone by 2020
- **Objective 14 (Partnerships and Linkages):** To establish an effective laboratory network at national and international level for quality laboratory services and resource mobilization by mid-2020.
- **Objective 15 (Quality Assurance):** To establish a Quality Management System (QMS) for quality assured laboratory test results by end 2020

Blood Services

- **Objective 1:** Conduct a landscape analysis and develop a new national strategy for the provision of blood services, as the previous plan expired in 2014.
- **Objective 2:** Strengthen donation drives in all districts through community awareness building, reagents and materials for blood screening, etc.

E. Expected Outputs and Outcomes

Supply chain: The primary goal for the health sector supply chain is the establishment of a new and well-functioning agency that can manage this function for the MoHS. Very detailed activities and outputs can also be found in the document listed in tabular format.

Laboratory services: The Executive Summary of the National Health Laboratory Strategic Plan contains a series of high level goals, as follows:

1. Capacitating all 14 district laboratories to perform all test menus of the BPEHS.
2. Strengthening all 5 centres of excellence facility laboratories as reference labs supporting district and PHU.
3. Coordinating partners supporting laboratories services as per national priority with geographic equity to produce tangible outcomes.
4. Instituting Public Health Laboratory network supporting IDSR.
5. Establishment of integrated outbreak response.
6. Establish professional regulatory body to structure and monitor laboratory staff.
7. Strengthening commodity security.
8. Support researches of national interest with defined outcomes.

A series of more detailed outputs and indicators are also available in the body of the document.

CHAPTER 6: HEALTH INFORMATION SYSTEMS & RESEARCH

A. Relevant Documents

Strategy or Policy	Responsible Entity
<ul style="list-style-type: none"> National Health Information System Strategic Plan – 2017 – 2021 	Directorate of Policy, Planning and Information

B. Vision and Mission

	Vision	Mission
HIS	Sierra Leone desires a user friendly Health Information System which provides timely, efficient and reliable information that is well functionally supported to guide evidence-based decision making	To generate quality information at source which stakeholders at all levels trust and use in driving health system decisions in the country

C. Current Status and Situation Analysis

Sierra Leone experienced firsthand the pitfalls of a non-functional health management information system (HMIS), which failed to detect the nascent EVD outbreak that would go on to claim thousands of lives across the country. Beyond epidemic surveillance, a well-functioning National Health Information System (NHIS) should also be able to provide timely, complete and accurate information down to the health facility level on morbidity, mortality and health system performance.

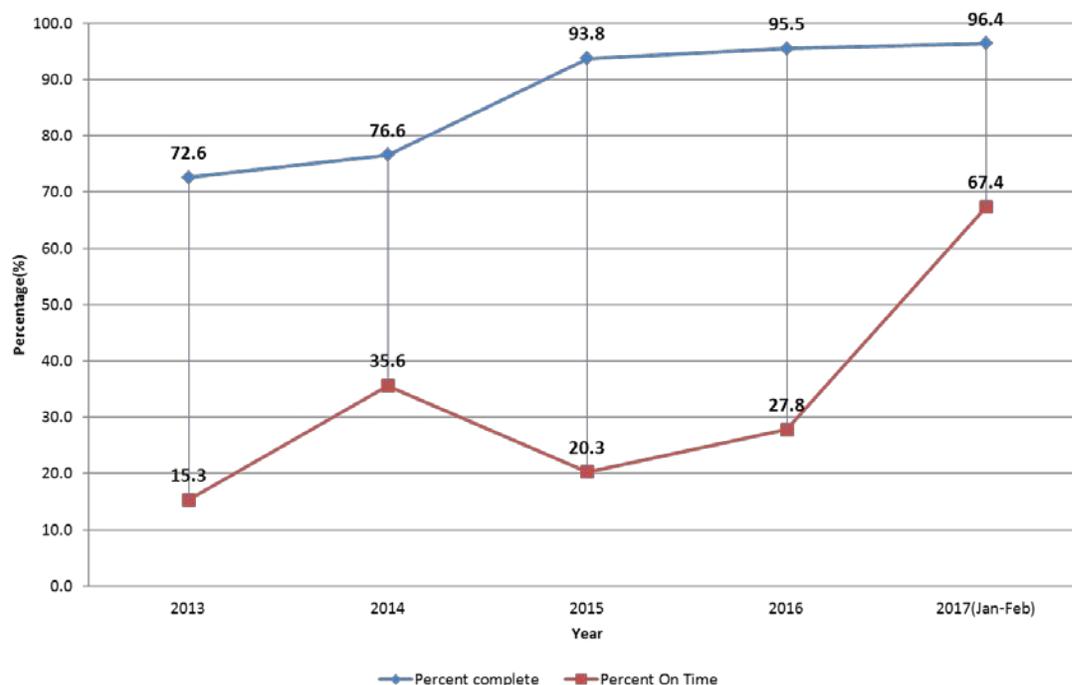
At present, Sierra Leone’s NHIS, which is managed by the Directorate of Policy, Planning and Information, relies on a combination of paper-based and electronic systems for the collection and management of most of its health data. DPPI uses the District Health Information System (DHIS2), developed by the University of Oslo, for the management of its electronic data. Other targeted systems also exist within the MoHS and are managed in parallel, such as the Human Resources Information System (HRIS), which provides data on the health workforce, and the Logistics Management Information System (LMIS), which provides data on drug distribution and consumption. Discussions are ongoing regarding intra-Ministry systems integration. NHIS completeness is relatively strong, and timeliness is improving; however, there are widespread doubts about the accuracy of the data collected.

Within the broader GoSL, a Civil Registration and Vital Statistics (CRVS) system incorporates data across the MoHS, Ministry of Internal Affairs, Ministry of Justice and Statistics Sierra Leone (SSL), and is managed by a new National Civil Registration Authority. Other data relevant but not specific to the health sector – such as the recent census results – are managed by other government agencies or groups, such as SSL. Some health indicators have been collected sporadically by the President’s Delivery Team, and various health development partners and NGOs also occasionally or routinely are involved with the collection of health data as well. Only some of this information is integrated into the NHIS.

Structural deficiencies across the system – which contribute to the NHIS’ challenges – include unavailability of computers and IT services; lack of resources to pay for internet services; poor internet services even once paid for; integration and interoperability among different software products (NHIS,

LMIS, HRIS) that later need to be linked together; poor health worker motivation with respect to the NHIS; and a lack of organization and enforced registration around the births and deaths registry. A 'declaration' was made at a meeting attended by MoHS, GoSL and health development partner stakeholders that aimed to address some of these challenges. In addition, DPPI has recently developed a new strategy for the 2017-2021 period with guidance from the WHO's framework and standards for country health information systems. Furthermore, innovative technologies are being explored to support various aspects of service delivery, which extend beyond the scope of the NHIS and which covers several components, including the use of digital health for a variety of aspects cutting across several components of the health system.

Figure 8: Percentage of NHIS Data Completeness and Timeliness – 2013 – 2016



D. Objectives, Actions and Targets

The following draws from the current Objectives and Targets that have been validated and launched through the HIS Strategy process. Please note that the text below is drawn directly from the text of the HIS Strategy document. Objectives and targets include:

- **Strategic Objective 1 (Governance and Leadership): To ensure that the health information system is appropriately governed and provided leadership:**
 - **1.1.** Develop Policy, Plans, SOPs and guidelines and distribution to stakeholders that will aid the performance and functionality of the HIS
 - **1.2.** Foster HIS governance through the creation of coordination and leadership structures
 - **1.3.** Provide opportunity for stakeholders to make input and grant feedback to the HIS structure and performance

- **1.4.** Allocate and advocate for resources for the National HIS and monitor the disbursement and utilization of the resources
- **1.5.** Ensure that HIS data is publicly available to help encourage accountability
- **Strategic Objective 2 (Information System & Tools): To develop a health information system that provides quality data, supported by analytical tools and facilitates its use at all levels:**
 - **2.1.** Harmonize indicators and provide linkages to all data sources
 - **2.2.** Carry out data quality improvement activities
 - **2.3.** Develop Decision Support tools for the national DHIS
 - **2.4.** Establish communication channels to disseminate information gathered
 - **2.5.** Coordinate and collaborate on population based data sources
 - **2.6.** Conduct a facility readiness assessment
- **Strategic Objective 3 (Infrastructure and Architecture): To facilitate the development of the HIS on an infrastructural and architectural framework that is supported locally, sustainable and scalable:**
 - **3.1.** Invest in a data center and server that will be able to host the national health information backbone
 - **3.2.** Review and assess periodically the state and performance of the infrastructure to ensure data guiding principles are in place
 - **3.3.** Ensure all health facilities with connectivity are able to collect and report data electronically
 - **3.4.** Build capacity in HIS and data management
 - **3.5.** Develop processes for managing official government policies and documents in the MoHS
- **Strategic Objective 4 (Standards for Integration & Interoperability): To support the establishment and adoption of standards that will aid continuity, integration and interoperability of HIS:**
 - **4.1.** Establish and operate the Government body that leads, coordinates and regulates digital initiatives (e-health coordination hub)
 - **4.2.** Develop and/ or adopt standards that will facilitate health facility information system integration and interoperability
 - **4.3.** Integrate the National DHIS2 with other sub-systems
- **Strategic Objective 5 (Monitoring and Evaluation): To monitor and evaluate the performance of the HIS**
 - **5.1.** Monitor the implementation of the national health information system strategic plan
- **Strategic Objective 6 (Research)³¹: To develop new research for health in Sierra Leone**
 - **6.1.** Develop a list of health-related research questions critical to the delivery of quality health services
 - **6.2.** Carry out select/crucial health research projects through the Directorate of Policy, Planning and Information

E. Expected Outputs and Outcomes

³¹ This objective does not appear in the HIS Strategic Plan, and has been included as a result of the regional consultations.

The HIS Strategy does not have a table of specific outputs; however, a detailed implementation plan is available with the primary document.

CHAPTER 7: HEALTH SECURITY AND EMERGENCIES

A. Relevant Documents

Strategy or Policy	Responsible Entity
<ul style="list-style-type: none"> National Environmental Health and Sanitation Strategy – 2016 – 2020 	Directorate of Environmental Health and Sanitation
<ul style="list-style-type: none"> Integrated Pest Management Plan (for the REDISSE Project) 	Under discussion
<ul style="list-style-type: none"> National Public Health Agency Strategy 	National Public Health Agency

B. Mission and Vision

	Vision	Mission
Environmental Health	To have functional national health systems that are delivering efficient, high quality health care services that are accessible, equitable and affordable for everybody in Sierra Leone.	To contribute to socio-economic development by employing all scientific, disease prevention and participative approaches to make Sierra Leone a pollution-free nation.
Animal Health	---	To bring together, into a workable combination the best strategies of all control methods that apply to a given problem created by the activities of pests.
Public Health	A Healthy Sierra Leone through evidence based leadership in Public Health.	To secure the health of Sierra Leone, as the trusted source of Public Health information, guidance and leadership.

C. Current Status and Situation Analysis

The One Health approach that the MOHS is pursuing involves joint solutions to address and bridge human health, environmental health and animal health issues. The preceding chapters have discussed in depth the MoHS' plans in the human health arena; this chapter discusses in more detail the particular strategies related to environmental health and sanitation; pest management and animal health; the establishment of a new entity within the GoSL system to improve the management of public health and emergencies within Sierra Leone; and finally health promotion.

Environmental Health and Sanitation

Sierra Leone is presently facing a number of challenges regarding environmental health and sanitation, which is managed in the MoHS structure through a recently created Directorate of Environmental Health and Sanitation. Cultural barriers abound, and there is a 'deeply entrenched' culture of open defecation in many communities. All liquid waste is discharged without treatment into bodies of water. More than 80% of under-five deaths at the hospital level can be traced back to environmental health and sanitation concerns, such as malnutrition, respiratory infections and anemia. Funding is a serious

challenge – while significant efforts have been put towards this area through the President’s Recovery Priorities, the government allocates minimal resources in its budget.

Animal Health

The Regional Disease Surveillance Systems Enhancement Project (REDISSE), funded through the World Bank, is designed to strengthen weak human health, animal health, and disaster response systems in West Africa to guard against future epidemics. Animal health, and in particular safeguarding against zoonotic diseases, is a critical part of this effort, with the most stark example of this being the Ebola epidemic that swept across Sierra Leone, Liberia and Guinea. Pests such as mosquitoes also enact a significant toll on the population through the transmission of malaria, and other vectors also contribute to overall morbidity and mortality (e.g., black flies and onchocerciasis). At present, pests are managed through cultural/agricultural means, biological means and chemical controls, although the capacity for pest management generally remains weak. Sierra Leone’s pest management efforts form a key part of animal health activities, and ultimately delivering on the promise of the REDISSE project.

Public Health

Sierra Leone has made some significant strides on public health-related efforts since the end of the Ebola epidemic in 2015. As a result of lessons learned from the epidemic, newly available resources for public health improvements, and fresh focus on the issue from the MoHS and President’s Delivery Team, a number of strides have been made in recent months. These include improvements to the disease surveillance and response system, the readying of rapid response teams, upgrading laboratory capacity and the establishment of a standing Emergency Operations Centre. However, there is still much to be done, and the November 2016 Joint External Evaluation found a number of remaining gaps in Sierra Leone’s public health landscape and compliance with International Health Regulations. As a result, the MoHS has decided to launch a new National Public Health Agency (NPHA) to build on the successes of the past several years and address the remaining gaps found by the Joint External Evaluation mission.

D. Objectives, Actions and Targets

The following draws from the strategies and plans noted above. Please note that some text below is drawn directly from the objectives and activities outlined in these documents.

- **Strategic Objective 1 (Environmental Health and Sanitation):** Improve environmental health and sanitation practices to curb mortality³²
 - **1.1. (Housing):** *To Develop a framework for the inspection and control of housing and country planning activities to address environmental health and sanitation issues in building plans and compound layouts.*
 - **1.2. (Food Safety and Quality Control):** To ensure that all local and imported food served to the public in Sierra Leone, and the premises where the food is served, are regulated to protect the health of the public. This includes the establishment of food safety regulations for food handlers.
 - **1.3. (Integrated Waste Management):** To ensure that all health facilities, educational establishments, all manufacturing and mining industries, business firms, public buildings,

³² Please note that the Environmental Health and Sanitation Strategy includes a full 23 objectives. As the first 16 focus on cross-cutting leadership, governance and management issues that are touched on elsewhere in the document, this section focus on the final 7, all of which constitute the core service areas of the Directorate of Environmental Health and Sanitation.

markets, parks, households and rural communities are practicing environmentally safe methods of waste disposal.

- **1.4. (Integrated Vector Management):** To reduce by 80% the incidence of diseases attributable to vectors and neglected tropical diseases and to review and update the Integrated Vector Management Policy and Strategy.
 - **1.5. (Occupational Health and Safety Programme):** To provide tools for the effective implementation of the Occupational Health and Safety Programme of the Directorate of Environmental Health and Sanitation.
 - **1.6. (Port Health Services):** To develop the strategic action plan for the Port Health Services Programme and to lay down the framework governing the movement, through Sierra Leone's ports of entry and exit, of illegal and harmful drugs and substances of environmental and public health importance.
 - **1.7. (WASH):** To improve WASH through the development of technical guidelines for construction of sanitation facilities; and to increase supportive supervision, monitoring and testing of potable water and sanitation services
-
- **Strategic Objective 2 (Animal Health):** Improve the integrated management of pests and animals
 - **2.1. (Technical capacity):** Enhance the capacity of health workers and veterinarians to contribute to human and animal health disaster reduction through environmentally friendly pest management practices.
 - **2.2. (Specimen transport and disposal):** Improve the efficiency of specimen transport and disposal system
 - **2.3. (Chemical use):** Increase awareness on use and safety of application of chemicals for pest/vector control
 - **2.4. (Lessons learned):** Document and disseminate key lessons to users and stakeholders
 - **2.5. (Food safety):** Reduce the use of harmful or banned chemicals/pesticides in growing foods for human and animal consumptions
-
- **Strategic Objective 3 (Public Health):** Establish the Sierra Leone National Public Health Agency to improve public health, guard against outbreaks and respond to emergencies
 - **3.1. (Surveillance):** Establish a functional integrated public health surveillance system that provides timely evidence for public health action (prevention, detection and response).
 - **3.2. (Laboratory Capacity):** Establish an effective public health reference laboratory, linked to surveillance and capable of supporting ongoing improvements.
 - **3.3. (Emergency Preparedness, Resilience and Response):** A health system that is able to effectively prepare for and respond to public health emergencies
 - **3.4. (Workforce):** A sustainable workforce, capacitated and skilled to meet the public health needs of Sierra Leone.
 - **3.5. (Research):** A strong and coordinated public health research capacity that informs policy and public health programs.
 - **3.6. (Prevention and Promotion):** Effective prevention of disease, through effective public health advocacy, education, services and policy development.
-
- **Strategic Objective 4 (Health Promotion):** Improve health promotion in Sierra Leone through community engagement, social mobilization, communication campaigns and other means
 - **4.1. (Strengthen Health Promotion Structures):** Rejuvenate the SM and communications pillars; strengthen coordination mechanisms between national- and district-level partners; strengthen

the coordination, technical and leadership capacity of district-level health promotion and related structures; clarify the roles and responsibilities of community-level actors; define accountability mechanisms for addressing community concerns and strengthen, rejuvenate and reinvigorate community groups; and foster community ownership of health.

- **4.2. (Strengthen National Health Promotion Interventions):** Disseminate and provide guidelines on the use of health promotion models; support national integrated efforts to reach adolescents; establish and strengthen key change agents; strengthen health promotion interventions; ensure an evidence base for determining key behavioral determinants and communication channels in programming; prioritize health promotion needs across the MOHS unit; develop and launch a national campaign; develop and implement an emergency communication plan; and strengthen the integration of health promotion activities.
- **4.3. (Improve Human Resources and Capacity Strengthening for Health Promotion):** Develop a training programme for pre-service and in-service health promotion professionals and to clarify workforce policy regarding health promotion.
- **4.4. (Raise Awareness and Mobilize Resources for Strengthened Health Promotion):** Advocate for increased resources to support health promotion human resources, operational needs and activities, and to recruit private sector partners to protect families and communities.
- **4.5. (Improve M&E Systems for Health Promotion):** Strengthen health promotion indicators and develop a monitoring system to report against those indicators; to create an monitoring and evaluation (M&E) subcommittee within the SM Pillar; to develop a framework for programme partners on health promotion M&E; and to implement key methodologies on a national level, including representative quantitative surveys.
- **4.6. (Strengthen Knowledge Sharing and Management):** Develop a national health promotion knowledge management plan; a national health promotion library of data, resources and best practices; and a national health promotion community of practice.

E. Expected Outputs and Outcomes

Environmental Health and Sanitation

The Environmental Health and Sanitation Strategy includes very detailed activities and results – please refer to that document for further detail.

Animal Health

The Integrated Pest Management Plan contains the following goals:

- Improved public & animal health
- Increased national and community surveillance & preparedness on human and animal health risk disaster management
- Increase capacity of institutions to manage health emergencies/outbreaks in environmental and socially safe manner
- Increase number of private laboratories for diagnosis of infectious human and animal health

Public Health

The National Public Health Agency Strategy is still in draft form and does not have a fully developed list of outputs and outcomes. The primary goal is the launch of the Agency.

CHAPTER 8: COMMUNITY ENGAGEMENT AND HEALTH PROMOTION

A. Relevant Documents

Strategy or Policy	Responsible Entity
<ul style="list-style-type: none"> Community ownership as part of the Health Sector Recovery Plan – 2015-2020 	Directorate of Primary Healthcare
<ul style="list-style-type: none"> National Health Promotion Strategy – 2017 – 2021 	Directorate of Primary Healthcare
<ul style="list-style-type: none"> Community Health Worker Strategy – 2017 – 2021 	Directorate of Primary Healthcare

B. Vision and Mission

	Vision	Mission
Health Sector Recovery Plan	Community ownership forms a key pillar for attaining the vision and of the health sector recovery plan of a functional and resilient health system by 2020	
Health Promotion Strategy	Although not explicitly stated as vision and mission, the strategy seeks to re-conceptualize the role of health promotion in the health sector; places families and communities at the centre of planning and action; elevates the practice of health promotion; and focuses the action of a coalition of agencies.	
CHW Strategy	See chapter on HRH	

C. Current Status and Situation Analysis

The Government of Sierra Leone has numerous structures – formal and informal– that play a role in community engagement and health promotion. While many of these structures were active and important during the Ebola outbreak, some have since become redundant. However, government and partners have been able to sustain and strengthen key mechanisms, emphasizing the importance of building technical capacity to effectively manage and increase coordination among all community-linked structures. The current picture is mixed: while the national-level coordinating committee (National Social Mobilization Pillar) is functioning effectively and there has been an expansion of partnerships for health promotion, the District Social Mobilization Pillars need strengthening. In some areas, district-level coordinators have been appointed and campaigns targeted towards improving the health and wellbeing of the population significantly rely on the community for their success. Additionally, the media play vital role and key legislation (such as tobacco control) is being considered for overall health promotion.

The Directorate of Primary Healthcare, the Health Education Division is responsible for community engagement and social mobilization, message development and dissemination, mass media campaigns, etc. These activities are largely coordinated under a Social Mobilization pillar, which brings together government and partners to pursue joint health promotion activities. This pillar were critical in engaging communities to help bring the Ebola epidemic under control, and the Health Education Division is currently working to rejuvenate and expand the membership of these groups. These structures are also meant to coordinate with the CHW Hub and related working groups to ensure coordination between

health promotion and the direct community services that CHWs are providing on the ground. In practice, CHWs support community engagement activities to increase the reach of national campaigns, such as MCH week, immunization campaigns, malaria prevention activities, and have supported community engagement in response to outbreaks such as cholera and Ebola, linking back to PHUs.

The national conference on Community Engagement and Convergence, organized by the Government of Sierra Leone, in partnership with UNICEF, in 2016 defined the community engagement was a process to organize individuals, groups and networks in a more sustainable community structure to enable them to enhance ownership and social accountability to take leadership in:

- Making decisions on issues affecting their community
- Building accountability of decision-makers
- Monitoring the situation of children and the quality of services provided
- Changing behavior

D. Objectives, Actions and Targets

One of the key pillars of the Health Sector Recovery Plan 2015-2020 was around strengthening community ownership. To that end, several key areas were identified in the HSRP including: ensuring community groups of key stakeholders (dialogue structures including women and youth) and networks are established and systematically engaged in BPEHS implementation; key community groups and networks are engaged in community surveillance, case investigation and other key operational events; and key policies, strategies and guidelines on community engagement are developed to support the implementation of the BPEHS.

Many of these activities are being implemented, with the key founding documents being the CHW Policy and draft strategy (see section on HRH) and the Health Promotion Strategy. In addition to the above, the 'Community and CSO Led Accountability Initiative' coordinated by the Office of Chief of Staff aims to improve government's service delivery, transparency and accountability to improve the lives of the citizens, especially women and children in deprived communities, through civic engagement and participation.

The following draws from the current Objectives that have been validated and launched through the Health Promotion Strategy. Please note that the text below is drawn directly from the Executive Summary of the document.

Objective 1 Strengthen Health Promotion Structures: Priorities towards this objective are to rejuvenate the social mobilization and communications pillars; strengthen coordination mechanisms between national and district level and among partners; strengthen the coordination, technical, and leadership capacity of district-level health promotion and related structures; clarify the roles and responsibilities of community level actors and define accountability mechanisms for addressing community concerns and strengthen, rejuvenate, and reinvigorate community groups; and foster community ownership of health.

Objective 2 Strengthen National Health Promotion Interventions: Priorities towards this objective are to disseminate and provide guidelines on the use of health promotion models, support national integrated effort to reach adolescents with health promotion, establish and strengthen key change

agents, strengthen health promotion interventions, ensure an evidence base for determining key behavioural determinants and communication channels in programming; prioritize health promotion needs across MOHS unit, develop and launch a national campaign and develop, implement an emergency communication plan, and strengthen the integration of health promotion activities with activities in other sectors.

Objective 3 Improve Human Resources and Capacity Strengthening for Health Promotion: Priorities towards this objective are to develop a training programme for pre-service and in-service health promotion professionals and to clarify workforce policy regarding health promotion.

Objective 4 Raise Awareness and Mobilize Resources for Strengthened Health Promotion: The priorities towards this objective are to advocate for increased resources to support health promotion human resources, operational needs and activities, and to recruit private sector partners to protect families and communities.

Objective 5 Improve Monitoring and Evaluation Systems for Health Promotion: The priorities towards this objective are to strengthen health promotion indicators and develop a monitoring system to report against those indicators, to create an M&E subcommittee within the social mobilization pillar, to develop a framework for programme partners on health promotion M&E, and to implement key methodologies on a national level, including representative quantitative surveys.

Objective 6 Strengthen Knowledge Sharing and Management: The priorities towards this objective include the development of: a national health promotion knowledge management plan; a national health promotion library of data, resources, and best practices; and a national health promotion community of practice.

E. Expected Outputs and Outcomes

Although there are no explicit outputs/outcomes stated in the Health Promotion Strategy, it is aimed at contributing to improved health outcomes.

SECTION V: IMPLEMENTING HSSP 2017 – 2021

A. Lessons Learned From the HSSP I: 2015 – 2017

The assessment of the HSSP I: 2010 – 2015 conducted by the external review team is instructive in highlighting the successes and challenges of the previous sector plan. On the positive side, the review team found that certain ingredients of success – for example, high levels of political will and significant levels of activity across the sector – were present, especially during the later portion of the HSSP I period which coincided with the EVD outbreak. In addition, many of the critical structures required to operate the health sector, including recently launched bodies such as the SLA Unit and IHPAU, are operational. However, these achievements were not sufficient to carry forward the implementation of the HSSP I.

In particular, the review team highlights: i) insufficient ownership of and commitment to the previous HSSP; ii) the significant number of additional plans and policies that exist in the space, many of which lack sufficient thoughtfulness around fiscal space analyses and available resources; iii) the lack of policy dialogue and coordination, compounded by the absence of a commonly held vision and proactive coordination among MoHS and partners; and iv) limited focus within the health sector is focused on addressing the structural and technical challenges within the MoHS itself. These challenges appear among the most critical recommendations that the review team recommends addressing.

Many of these challenges will be addressed through the specific pillars described in this document. However, there is an overarching lesson to be taken from the review team’s work – the quality and thoughtfulness of the HSSP II will matter little if the enabling environment is not in place to ensure the actual implementation of its contents. This includes a need to fully finance the key aspects of the plan.

B. Phased Implementation

Building on the lessons learnt from the HSSP I, implementation of the HSSP II will be done in a phased manner, which will include establishing a framework through which the MoHS and partners can manage the HSSP II: 2017 – 2021:

- **Establish a dedicated HSSP II Secretariat:** One of the challenges with a sector-wide plan is that the activities described herein are split across multiple Directorates – without an overarching management structure, plan achievements will vary widely depending on the engagement and level of interest of various stakeholders. Nor will the plan be the sole province of a single Directorate. Instead, the MoHS could appoint an HSSP II Manager, with reporting lines to be decided, along with a handful of junior support staff. The Manager will be provided with a clear TOR and mandate to coordinate and follow-up the key components of the plan across the Directorates, Programmes, DHMTs and partners. The structure will draw on lessons learned from the PDT experience, which was set up for similar purposes.
- **Streamline HSSP II activities into existing MoHS governance structures:** Reporting the HSSP will not be left to the end of the plan period. Progress and challenges related to the HSSP II will be built into MoHS midterm and annual reviews; and will be a standing agenda item on all quarterly Health Sector Coordinating Committee (HSCC) meetings; Health Sector Steering Group (HSSG) meetings; and quarterly DMO meetings. The PDT

structures that are being maintained, such as regular deep dives and some reporting, will be put to use in service of regular HSSP updates and follow-up. Agenda points, minutes, and follow-ups will be managed by the HSSP II Secretariat.

- ***Establish annual and mid-term HSSP review processes:*** The Secretariat will also be responsible for facilitating an annual review process through which plan progress is publicly discussed at the MoHS annual review; and an in-depth, multi-month mid-term review process at the end of year 2 of the plan to work with MoHS stakeholders and partners to adjust the course of the plan itself and create a revision – in content and targets – as necessary given progress over the first two years.

C. Annual operational plans

In order to ensure a bottom-up, participatory process, the MoHS will work closely with the DHMTs and district hospitals to develop annual operational plans. These plans will serve as the basis for identifying detailed needs at the sub-national levels, along with corresponding budgets and identification of indicators to track progress. They will also be linked to annual plans being developed by the different MoHS directorates and programmes, with regular feedback and dialogue among the different levels of the sector.

All of the above activities will be tied to the monitoring of the HSSP II (see Section VI below) to ensure regular reviewing, tracking and adjusting of plan is undertaken by all key stakeholders.

SECTION VI: MONITORING AND EVALUATION

Building on the Health Information Systems (HIS) Strategy 2017-2021, the MoHS will track progress towards the key targets outlined in the table below. This will take into account the monitoring, supportive supervision and information needs for the HSSP II.

In addition, a schedule of monitoring and supportive supervision missions will also form part of the monitoring and evaluation, and will draw on the work being undertaken as part of the President's Recovery Priorities and the integrated supportive supervision visits.

The primary data source for the indicators will be from the DHIS-2 and will be supplemented by programmatic assessments, surveys, support supervision reports and studies, as needed. In addition to the central level indicators, district level indicators will facilitate regular district-level performance assessments. At the district level, DHMTs, which include M&E officers, will be responsible for regular reporting of the indicators.

These activities will serve to inform periodic sector reviews (mid-year and annual), which will bring together all the key government stakeholders and partners to track progress, identify gaps and take remedial actions to address salient challenges that serve as a barrier to the successful implementation of the HSSP II.

A final evaluation of the HSSP II will be conducted to assess the overall impact of the investments and the health gains achieved over the implementation period.

PROPOSED INDICATORS FOR HSSP II: 2017 - 2021

Category	Baseline (From MoHS Review)	Source	2019 Target	2021 Target
Mortality by age and sex				
<ul style="list-style-type: none"> • Under 5 mortality rate (Probability of dying by age 5 per 1,000 live births) 	120 156	(UN 2015) (DHS 2013)		
<ul style="list-style-type: none"> • Infant mortality rate (Probability of dying by age 1 per 1,000 live births) 	87 92	(UN 2015) (DHS 2013)		
<ul style="list-style-type: none"> • Neonatal mortality rate (Probability of dying by 28 days per 1,000 live births) 	35 39	(UN 2015) (DHS 2013)		
Mortality by cause				
<ul style="list-style-type: none"> • Maternal mortality ratio (Deaths per 100,000 live births) 	1,360 1,165	(UN 2015) (DHS 2013)		
Fertility				
<ul style="list-style-type: none"> • Adolescent fertility rate (Live births per 1,000 girls aged 15-19) 	117 125	(UN 2015) (DHS 2013)		
<ul style="list-style-type: none"> • Total fertility rate (Average number of children per woman) 	5.2 4.5 4.9	(Census 2015) (UN 2015) (DHS 2013)		
Morbidity				
<ul style="list-style-type: none"> • HIV prevalence rate among adults aged 15-49 (% adults aged 15-49 living with HIV) 	1.30%	(UNAIDS 15)		
<ul style="list-style-type: none"> • TB prevalence rate (no. of cases of TB in a population at a given point in time / 100,000 pop.) 	441	(WHO 2014)		
<ul style="list-style-type: none"> • Malaria incidence rate (Number of confirmed reported malaria cases per 1,000 persons per year) 	229.4	(IDSR 2016)		

Reproductive, maternal, newborn, child and adolescent				
<ul style="list-style-type: none"> • Demand for family planning satisfied with modern methods (% of sexually active women aged 15-49 who have their need for family planning met with modern methods) 	37.50%	(DHS 2013)		
<ul style="list-style-type: none"> • Contraceptive prevalence rate (% of women aged 15-49 in a marriage or union who (or who's partner) are using at least 1 method of contraception) 	16.60%	(DHS 2013)		
<ul style="list-style-type: none"> • Antenatal care coverage (% of total (estimated) pregnant women attending ANC 4+) 	65.6%	(DHIS2 2016)		
	76.0%	(DHS 2013)		
<ul style="list-style-type: none"> • Births attended by skilled health personnel (% deliveries attended by Dr, SRN, m/w, CHO, SECHN, MCH aide) 	Min: 72.8%	(DHIS2 2016)		
	Max: 87.0%	(DHIS2 2016)		
	59.7%	(DHS 2013)		
<ul style="list-style-type: none"> • Postpartum care coverage (% women receiving 1st postpartum contact within 48h) 	Min: 82.7%	(DHIS2 2016)		
	Max: 98.8%	(DHIS2 2016)		
	72.7%	(DHS 2013)		
<ul style="list-style-type: none"> • Care-seeking for symptoms of pneumonia (% of children <5 with suspected pneumonia in the 2 weeks preceding the survey taken to a HF) 	71.70%	(DHS 2013)		
<ul style="list-style-type: none"> • Children with diarrhoea receiving ORS (% of children <5 with diarrhoea in the 2 weeks preceding the survey receiving ORS) 	85.10%	(DHS 2013)		
<ul style="list-style-type: none"> • Vitamin A supplementation coverage (% children receiving 2 age-appropriate doses of vitamin A in the past 12 months) 	99.98%	(EPI 2016)		
	83%	(DHS 2013)		
Immunization				
<ul style="list-style-type: none"> • Immunisation coverage rate (% of target population receiving the last recommended dose) 	88%	(EPI 2016)		
HIV				
<ul style="list-style-type: none"> • Anti-retroviral therapy (ART) coverage (% people living with HIV currently receiving ART treatment) 	32.5%	(NACP 2016)		
	29%	(UNAIDS 15)		

Tuberculosis			
<ul style="list-style-type: none"> • TB case detection rate (% estimated new and relapse TB cases detected and reported) 	60%	(WHO 2015)	
Malaria			
<ul style="list-style-type: none"> • Use of insecticide treated nets (ITNs) by under 5s (% of under 5s who slept under an ITN the previous night) 	44.10%	(MIS 2016)	
Nutrition			
<ul style="list-style-type: none"> • Children under 5 years who are stunted (% of children under 5 years with height-for-age >2 SD below median) 	28.80%	(NNS 2014)	
<ul style="list-style-type: none"> • Children under 5 years who are wasted (% of children under 5 years with weight-for-height >2 SD below median) 	4.70%	(NNS 2014)	
Environmental risk factors			
<ul style="list-style-type: none"> • Population using safely managed drinking-water services (% of whole population using safely-managed drinking water services) 	69.50%	(MIS 2016)	
<ul style="list-style-type: none"> • Population using safely managed sanitation services (% of whole population using safely-managed sanitation services) 	16.80%	(MIS 2016)	
Access			
<ul style="list-style-type: none"> • Availability of essential medicines and commodities 	<i>To be included by NMSA</i>		
Health workforce			
<ul style="list-style-type: none"> • Doctors, nurses (higher cadres), and midwives per 10,000 population (number of staff in these cadres per 10,000 pop.) 	140.00%	DHRH 2016	
Health information			
<ul style="list-style-type: none"> • Completeness of HMIS reporting by facilities (target: >90%) (% of health facilities submitting reports) 	95.80%	(DHIS-2 2016)	
<ul style="list-style-type: none"> • Completeness of LMIS reporting by facilities (target: >80%) (% of health facilities submitting reports) 	72.70%	(DHIS-2 2016)	
<ul style="list-style-type: none"> • Completeness of IDSR reporting by facilities (target: >80%) (% of health facilities submitting reports) 	92%	(IDSR 2016)	

Health financing			
<ul style="list-style-type: none"> • General government expenditure on health (% of total government expenditure) 	11.20% (NHA 2013)		
<ul style="list-style-type: none"> • Out-of-pocket payment for health (% of current expenditure on health) 	61.60% (NHA 2013)		

SECTION VII: COSTING NOTES

This plan was constructed in large part through the collation of all of the many sub-sector plans that have been developed in Sierra Leone’s health sector since the end of the Ebola epidemic. It has not been costed separate and apart from those plans, as many of those sub-sector plans are already funded, in full or in part, and activities are being conducted against these sub-sector budgets. The MoHS did not want to introduce yet another sector budget that would serve only to confuse as opposed to clarify, especially given that the process for the new Health Financing strategy has yet to begin. We hope that the Health Financing strategy process is able to collate and develop a rigorous sector-wide budget, resource map, and processes to better manage the flow of funds.

However, this plan contains a great number of objectives and activities, and these activities will surely have costs associated with them. In order to provide a general sense of the order of magnitude of cost associated with future plans for Sierra Leone’s health sector, the authors collated the total plan costs from the various sub-sector strategies, which appear in the following table. Please note that the sub-sector plans were all costed using different methodologies; at varying levels of detail; for different time periods; and with activities that would surely be complementary and introduce economies of scale if all of the activities were considered together instead of in their own individual silos.

Given these caveats, it is not possible to simply add up all of the following cost estimates to provide an overall total budget for the health sector. But the following estimates will provide a sense of the kinds of resources that the sector will require over the coming years if the MoHS and partners together want to ensure a significant impact on health indicators in Sierra Leone.

Table: Summary of Sub-Sector Plan Costs

Strategy or Plan Title	Years	Budget
Service Delivery (Chapter 2)		
<i>Sierra Leone HIV National Strategic Plan</i>	<i>2016 - 2020</i>	\$357M
<i>National Leprosy and TB Strategic Plan</i>	<i>2016 - 2020</i>	\$21M
<i>Malaria Control Strategic Plan</i>	<i>2016 - 2020</i>	\$126M
<i>Insecticide Resistance Monitoring and Management Plan</i>	<i>2017 - 2020</i>	\$2M
<i>Sierra Leone National RMNCAH Strategy</i>	<i>2017 - 2021</i>	\$545M³³
<i>EPI Comprehensive Multi Year Plan for Vaccines</i>	<i>2017 - 2021</i>	\$103M
<i>National Food Security and Nutrition Security Implementation Plan</i>	<i>2013 - 2017</i>	\$129M³⁴
<i>Mental Health Policy and Strategic Plan</i>	<i>2017 - 2021</i>	Uncosted
<i>Master Plan for Neglected Tropical Diseases in Sierra Leone</i>	<i>2016 - 2020</i>	\$8.M
<i>National Infection & Prevention Control Action Plan</i>	<i>2016 - 2019</i>	\$6M
Human Resources for Health (Chapter 3)		
<i>Human Resources for Health Strategy</i>	<i>2017 - 2021</i>	\$80M
<i>Community Health Worker Strategy</i>	--	--
Medical Products and Health Technologies (Chapter 5)		

³³ This total includes a significant number of HSS-related costs that would be duplicative to some of the costs in the other HSS-focused plans

³⁴ This is the cost for the 2013 – 2017 plan; a new plan is under development now, and we assume that it would entail a similar level of costs

<i>National Medical Supplies Agency Operational Plan</i>	<i>2017 - 2018</i>	\$20M
<i>National Health Laboratory Strategic Plan</i> ³⁵	<i>2016 - 2020</i>	
Health Information Systems (Chapter 6)		
<i>Health Information Systems Strategic Plan</i>	<i>2017 - 2021</i>	\$15M
Environmental Health, Animal Health, Public Health and Health Promotion		
<i>National Environmental Health & Sanitation Strategy</i>	<i>2015 - 2020</i>	Uncosted
<i>Integrated Pest Management Plan</i>	<i>2016 - 2020</i>	\$1M
<i>National Public Health Agency Operational Plan</i>	<i>2017 - 2019</i>	\$2M
<i>National Health Promotion Strategy of Sierra Leone</i>	<i>2017 - 2021</i>	\$3M

³⁵ This plan contains sample costs at an individual PHU level, but not a national total

ANNEXES

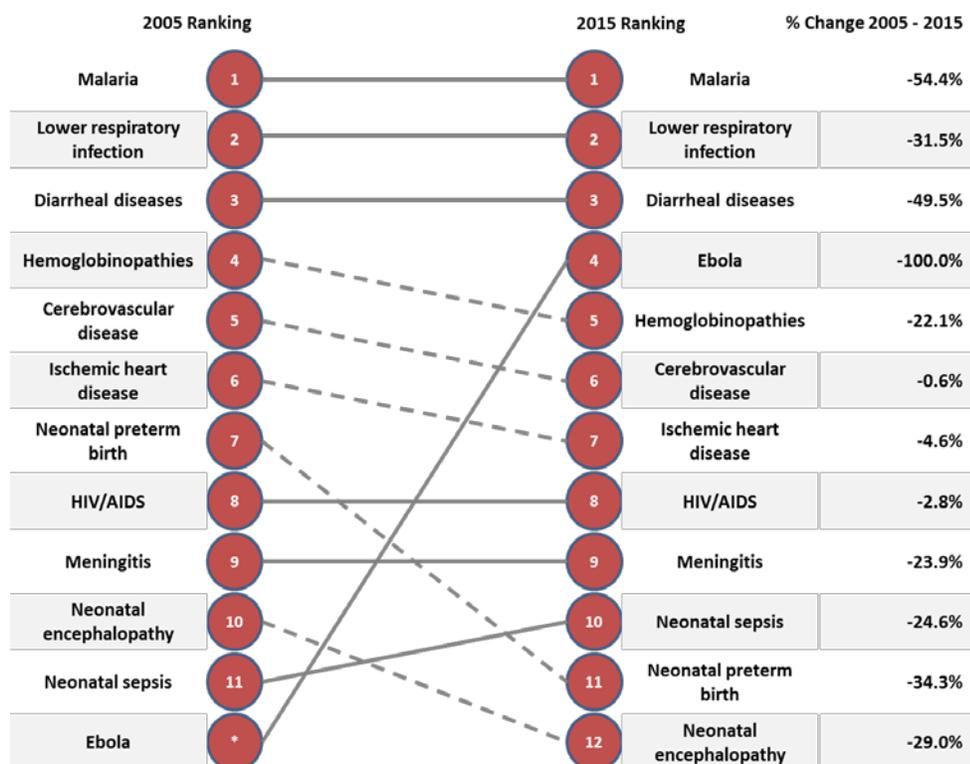
ANNEX 1: FURTHER BACKGROUND ON THE BURDEN OF DISEASE

Relative Mortality and Risk Factors

Given the burdens described above, what are Sierra Leone’s most significant health challenges? The Institute for Health Metrics and Evaluation releases their Global Burden of Disease Estimates every five years, which provides a useful complement to the DHS and MICS data points. While the GBD relies on modeled estimates – and so individual data points should be considered carefully – the review provides a useful ranking of mortality by cause. Perhaps unsurprisingly, the GBD estimates that malaria, lower respiratory infections and diarrheal diseases remain the primary causes of death in Sierra Leone.

The greatest risk factors that contribute most significantly to the overall burden of disease are malnutrition – through lower respiratory infections, diarrheal disease, maternal disorders and nutritional deficiencies; air pollution, which contributes to lower respiratory infections, cardiovascular disease and cancers; high blood pressure, which contributes to cardiovascular disease and other NCDs; and WASH, which contributes to diarrheal disease and lower respiratory infections.³⁶ Both these causes of mortality as well as the risk factors contributing to Sierra Leone’s highest burdens of disease are discussed further the below Chapter on Service Delivery.

Figure: Causes of Mortality by GBD Ranking



³⁶ Global Burden of Disease. Institute of Health Metrics and Evaluation.

ANNEX 2: FURTHER BACKGROUND ON MANAGEMENT AND GOVERNANCE

Central Ministry Leadership: The Ministry of Health and Sanitation (MoHS) is led by the Minister of Health and Sanitation. He is supported by two Deputy Ministers. The functions of the MoHS are further divided into the Professional Wing, managed by the Chief Medical Officer (CMO); and the Administrative Wing, managed by the Permanent Secretary (PS). Within the Professional Wing, the CMO is supported by two Deputy Chief Medical Officers as well as the Chief Nursing and Midwifery Officer; the PS is also supported by two Deputy Secretaries. The Professional and Administrative wings are further subdivided into a series of Directorates, Programmes, Units, Agencies and other entities. The Figure on the following page provides a general overview of the various bodies that are responsible for the overall governance of the health system as well as leadership on specific focus areas.

District Health Management Teams: Each of Sierra Leone's districts has a District Health Management Team, which is led by a District Medical Officer (DMO) and is responsible for cross-cutting managerial functions at the sub-national level. Staff includes the District Health Sister, District Pharmacist, District M&E Officer, and so on, and the staff of the DHMT is responsible for serving as a link between the health facilities under their purview and the central level policymakers in the MoHS. Local councils – under the purview of the Ministry of Local Government and Rural Development – are engaged at varying levels in health across the individual districts, which can extend to the purchase of drugs for local hospitals or other activities that are key to the functioning of the district.

Health Regulatory Bodies: There are also several Health Regulatory Bodies – the Sierra Leone Medical and Dental Council; the Sierra Leone Nurses and Midwives Board; and the Sierra Leone Pharmacy Board. All are responsible for the licensing and supervision of their respective health worker cadre(s). The Pharmacy Board has the additional responsibility of regulating pharmaceutical products through product registration, quality testing and post-market surveillance. Planned legislation (described above) will transition the Nurses and Midwives Board to a Council, which would make it autonomous from the Ministry; and to introduce a new body to govern the regulation of allied health professionals, such as Community Health Officers, Laboratory Technicians, etc.

Additional Agencies: Several agencies or other bodies are also in the process of being designed and launched that fall outside of the definitions above – including the National Medical Supplies Agency, which would operate the health sector supply chain; the National Public Health Agency, which would consolidate public health services across the MoHS; the National Emergency Medical Services, which will manage a new fleet of ambulances; and Sierra Leone Social Health Insurance, which is designing a new social health insurance program through the Ministry of Labor. Finally, the Sierra Leone Health Services Commission – a unit of the Public Service Commission – is responsible for recruitment of health workers.

Development Community: The health sector is heavily donor dependent, drawing significant financial contributions from such organizations such as The Global Fund, GAVI, the World Bank, the US Agency for International Development (USAID), UK Department for International Development (DFID), European Union (EU), JICA, German Development Cooperation (KfW & GIZ), the Chinese government and others. The World Health Organization (WHO), UNFPA and UNICEF are the lead UN organizations on matters related to the health sector. In addition to these financial contributions, the health sector also plays host to a significant number of NGOs and technical assistance providers, who work at all levels of the health sector in various capacities.

ANNEX 3: FURTHER BACKGROUND ON SERVICE DELIVERY STRUCTURES

Health Facilities: Sierra Leone has roughly 1,200 public health facilities, although the number of facilities and their designated levels of care frequently change as new facilities open and existing facilities close. The following data is drawn from the facility list used to prepare for the most recent Service Availability and Readiness Assessment (SARA) survey, with fieldwork conducted in Q2 2017. At the facility level, there is varying engagement from local entities with a variety of different names – such as Facility Management Committees (FMCs) and Village Development Committees (VDCs). Regardless of nomenclature, these kinds of groups are designed to facilitate engagement from the local community and chiefdom officials in the management of the facility and the monitoring of its staff, supplies, services and patient outcomes. Facilities include:

- **Hospitals:** Sierra Leone has 24 hospitals – of which 9 are located in the Western Area, including the three primary tertiary hospitals: Connaught, which is the largest hospital in the country and provides specialty care across a range of areas; Princess Christian Maternity Hospital, which provides maternity services; and Ola During Children’s Hospital, which provides care for Sierra Leone’s children. Several other specialty care hospitals exist in the Western Area, such as the Kissy Mental Hospital. The remainder of Sierra Leone’s hospitals provides secondary referral care, with at least one hospital per district functioning as a Comprehensive Emergency Obstetric and Newborn Care (CEmONC) center.
- **PHUs:** There are roughly ~1,160 PHUs, although this number increases or decreases by a factor of roughly 50 facilities depending on regular openings and closings, as well as a lack of maintenance of a single master facility list by the MoHS. There are three types of PHUs:
 - **Community Health Centers (CHCs):** There are 227 CHCs, which are generally larger facilities that are meant to cover populations of roughly 10,000-20,000 individuals. They typically employ higher-skilled staff, such as Community Health Officers (CHOs), midwives and so on, with some focus on epidemiology and environmental health. Roughly XX of these facilities also function as Basic Emergency Obstetric and Newborn Care (BEmONC) centers.
 - **Community Health Posts (CHPs):** There are 320 Community Health Posts, which are medium-sized facilities designed to serve a population of roughly 5,000-10,000 individuals. They are generally staffed by lower-skilled health workers, such as State Enrolled Community Health Nurses (SECHNs) and Maternal and Child Health Aides (MCH Aides).
 - **Maternal and Child Health Posts (MCHPs):** There are 616 MCHPs, the most numerous of the various levels of care, which is meant to provide the first point of contact with the facility-based health system. These facilities are meant to be located at the village level and serve populations of less than 5,000 individuals. They are largely staffed by MCH Aides.

Community Health Workers (CHWs): Below the health facilities, a number of Community Health Workers are also operating at the village level, providing another layer of care. This cadre, along with the facility-based staff working within the health sector, will be discussed in Chapter on Human Resources for Health.

The catchment areas described above are meant to serve as guidelines, though conversations with district-level MoHS staff and analysis of the MoHS Payroll suggest that there is a great deal of variability in catchment area and staffing that does not necessarily match with a facility’s stated level of care. In addition, one of the critical challenges in the management of these facilities is the lack of a formal

process by which a facility is formally accepted or accredited by the central MoHS prior to opening; indeed, the HSSP review team indicated in their review that there may in fact be far too many health facilities in some areas, which has created an additional challenge in delivering quality health services.

Table: Public Health Facilities by District and Level of Care

District	Hospital	CHC	CHP	MCHP	Clinic	TOTAL
Bo	1	34	28	64		127
Bombali	1	20	71	9	2	103
Bonthe	2	12	16	28	1	59
Kailahun	1	12	50	18	1	82
Kambia	1	13	17	39		70
Kenema	1	26	30	64	2	123
Koinadugu	1	10	7	55		73
Kono	1	15	13	54	1	84
Moyamba	1	18	11	69	1	100
Port Loko	3	14	33	62	1	113
Pujehun	1	13	15	49		78
Tonkolili	1	12	8	84		105
Western Rural		10	15	18		43
Western Urban	9	18	6	3		36
Grand Total	24	227	320	616	9	1196

In addition to these public sector facilities, there is a small but important sector of private, nonprofit and faith-based facilities that also provide care in Sierra Leone.

ANNEX 4: SUSTAINABLE DEVELOPMENT GOAL 3 – STATUS IN SIERRA LEONE

Target	Indicator	Value	Year
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.	Maternal mortality ratio (per 100 000 live births)	1 360	2015
	Proportion of births attended by skilled health personnel (%)	60	2006–2014
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.	Under-five mortality rate (per 1000 live births)	120.4	2015
	Neonatal mortality rate (per 1000 live births)	34.9	2015
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.	New HIV infections among adults 15-49 years old (per 1000 uninfected population)	0.7	2014
	TB incidence (per 100 000 population)	310	2014
	Malaria incidence (per 1000 population at risk)	406.0	2013
	Infants receiving three doses of hepatitis B vaccine (%)	83	2014
	Reported number of people requiring interventions against NTDs	7 564 272	2014
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.	Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70 (%)	27.5	2012
	Suicide mortality rate (per 100 000 population)	5.6	2012
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.	Total alcohol per capita (> 15 years of age) consumption, in litres of pure alcohol, projected estimates	8.2	2015
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents.	Road traffic mortality rate (per 100 000 population)	27.3	2013
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.	Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)	37.5	2005–2015
	Adolescent birth rate (per 1000 women aged 15-19 years)	125.0	2005–2015
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.	N/A	N/A	N/A
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.	Mortality rate attributed to household and ambient air pollution (per 100 000 population)	142.3	2012
	Mortality rate attributed to exposure to unsafe WASH services(per 100 000 population)	90.4	2012
	Mortality rate from unintentional poisoning(per 100 000 population)	5.7	2012
3.a Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate.	Age-standardized prevalence of tobacco smoking among persons 15 years and older (% , male)	60.0	2015
	Age-standardized prevalence of tobacco smoking among persons 15 years and older (% , female)	12.0	2015

Target	Indicator	Value	Year
3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.	N/A	N/A	N/A
3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.	Skilled health professionals density(per 10 000 population)	1.9	2005–2013
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.	Average of 13 International Health Regulations core capacity scores	64	2010–2015
2.2 By 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons	Prevalence of stunting in children under 5 (%)	37.9	2005-2015
	Prevalence of wasting in children under 5 (%)	9.4	2005-2015
	Prevalence of overweight in children under 5 (%)	8.9	2005-2015
6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all	Proportion of population using improved drinking-water sources (%)	63	2015
6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all, and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations	Proportion of population using improved sanitation (%)	13	2015
7.1 By 2030 ensure universal access to affordable, reliable, and modern energy services	Proportion of population with primary reliance on clean fuels (%)	<5	2014
11.6 By 2030, reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality, municipal and other waste management	Annual mean concentrations of fine particulate matter in urban areas($\mu\text{g}/\text{m}^3$)	16.8	2014
13.1 strengthen resilience and adaptive capacity to climate related hazards and natural disasters in all countries	Average death rate due to natural disasters(per 100 000 population)	<0.1	2011-2015
16.1 significantly reduce all forms of violence and related death rates everywhere	Mortality rate due to homicide(per 100 000 population)	13.0	2012
	Estimated direct deaths from major conflicts(per 100 000 population)	0.0	2011-2015

Source: World Health Statistics 2016: Monitoring health for the SDGs, http://www.who.int/gho/publications/world_health_statistics/2016/en/

ANNEX 5: RESOURCES

Most of the key documents referenced in this plan can be found on the MoHS repository: <https://mohs-portal.net/regulation/policies/>