

Sierra Leone

Health Sector Review

2004

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Acronyms

AfDB	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
CCSI	Community and Civil Society Initiative
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CHASL	Christian Health Association of Sierra Leone
CHC	Community Health Centre
CHP	Community Health Post
CMS	Central Medical Stores
CSO	Civil Society Organisation
DFID	Department for International Development
DHMT	District Health Management Team
DMO	District Medical Officer
DPC	Disease Prevention and Control
EDCUA	Endemic Disease Control Unit Assistant
EU	European Union
FGD	Focus Group Discussions
FGM	Female genital mutilation
FP	Family planning
GDI	Gender Development Index
GDP	Gross Domestic Product
GOSL	Government of Sierra Leone
GP	General Practitioner
HDI	Human Development Index
HH	Household
HIES	Household Income and Expenditure Survey
HIPC	Highly Indebted Poor Country
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Support Project (EU)
I-PRSP	Interim Poverty Reduction Strategy Paper
MCHP	Maternal Child Health Post
MDG	Millennium Development Goals
MICS	Multi-indicator Cluster Survey
MODEP	Ministry of Development and Economic Planning
MOHS	Ministry of Health and Sanitation
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NHA	National Health Accounts
NGO	Non-Governmental Organisation
PASCO	Poverty Alleviation Strategy Co-ordination Office
PER	Public Expenditure Review
PETS	Public Expenditure Tracking Survey
PHC	Primary Health Care
PHU	Peripheral Health Unit
PMO	Provincial Medical Officer
PPA	Participatory Poverty Assessment
PRSP	Poverty Reduction Strategy Paper
RH	Reproductive Health
RUF	Revolutionary United Front
SLIHLCS	Sierra Leone Integrated Household Living Conditions Survey
SSL	Statistics Sierra Leone
STI	Sexually Transmitted Infection

TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
TORs	Terms of Reference
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
UNFPA	United Nations Fund for Population Activities
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation

Executive Summary

The Government of Sierra Leone is preparing its first Poverty Reduction Strategy Paper (PRSP). It is hoped that the PRSP will provide the basis of a framework for the allocation of government and donor resources towards activities that are targeted towards poverty reduction and will form the basis for decentralised sectoral programmes which are fully integrated into the Medium Term Expenditure Framework (MTEF).

Unlike in other sectors, a significant amount of background research has been undertaken in the health sector, which has been used by government to guide planning. One such study was the Multi-Cluster Indicator Survey (MCIS 2000), the results of which were utilized during the preparation of the Interim PRSP. There are, however, significant information gaps that need to be filled in to provide a more complete assessment of the sector needs.

Objective

The objective of this review was to review current activities in the health care sector, make recommendations on changes based on the new poverty data and assist with the costing of any new programmes. The areas identified as having information gaps that need to be urgently addressed are health care financing and sustainability and health legislation. The full terms of reference for this review are attached in Annex 1.

Methodology

The methods used in carrying out this review included:

- Consultations and focused group discussions were held in all districts in the country, analysis attached in Annex 2.
- Interview of key stakeholders in the Ministry of Health and Sanitation and Development Partners, full list attached in Annex 3.
- Review of documentation including surveys, reports, records, policy documents, manuals and guidelines, full list attached in Annex 4;
- Extensive use of the preliminary findings of the Sierra Leone Integrated Household Living Conditions Survey, 2004.

Main findings

- The policy and strategic framework for the health sector is evolving, with many key policies still to be developed, e.g. human resources, health care financing, etc.
- There is disharmony between some of the current legislation guiding the sector and some of the legislation is outdated in terms of technology and social norms.
- Resources for the health sector are totally inadequate, even to deliver a basic level of health care.
- Resources for health are unevenly distributed throughout the country and raises questions on equity of distribution and access:
 - The top quintile, richest 20%, of the population account for 46% of the national household consumption on health (SLHICLS 2004).
 - The bottom quintile, poorest 20%, of the population account for 7% of the national household consumption on health (SLHILCS 2004).
 - Western Area average household size is 6.03 with the largest per capita annual consumption on health at Le.263,541.00 (approx. \$105)

- Kambia district average household size is 6.84 with the lowest per capita annual consumption on health at Le.26,382 (approx. \$10.55)
- Current criteria for allocation of resources and indicators measuring the performance of the sector do not fully address issues of equity and gender.
- Health was put in the top three or four priority areas to address poverty in participatory appraisals carried out.
- MOHS prioritises public health goods, activities with externalities and are targeted to the poor.
- The people are generally unhappy with the level of health care being provided in terms of: inadequate staffing, inadequate infrastructure and equipment, inadequate drugs and medical supplies and no provision for referral when needed.
- Formal and informal charging for health care is causing barriers to access and there is a drop in utilisation of health services as a result.
- There is large confusion by both health workers and the general public on exemptions and their criteria.
- The information systems in the health sector are weak and no data is disaggregated by sex.
- There is a lot of uncertainty and misinformation regarding devolution and how new organisational structures will relate to existing ones.
- Capacity for financial management is weak throughout the sector.
- Conditions of service for health workers are poor, both pay and non-pay, staff housing, water and sanitation, especially in rural areas, are below standard.
- There is a lot of investment going into the construction and rehabilitation of health facilities, without any real analysis of the recurrent cost implications.
- There are a large number of donors, churches, NGOs and agencies working in the health sector. The MOHS are trying to coordinate all these stakeholders. There is a revised National NGO Policy and Memoranda of Understanding are signed with various NGOs to meet the criteria as set out in the policy.
- There is widespread utilisation of the traditional health sector by the people, engagement to date has focused on traditional birth attendants, steps are being taken to address the situation and MOHS now have a policy on the role of the traditional health sector.
- The private for profit sector in Sierra Leone is still relatively small and linkages with the MOHS are weak.
- Forums for community participation exist at district level, but guidelines for membership do not ensure equal representation from women and men.

Main Recommendations

- The policy framework for the sector needs strengthening, starting with the approval of a national health policy and supported by a comprehensive framework of strategic and technical policies.
- The poorest need to receive more of the public expenditure on health
- The overall amount of funding for health needs to be drastically increased and the criteria for allocating resources needs to be revised to ensure equity,
- All inputs to the health sector needs increasing and improving, especially human resources, drugs and medical supplies and basic equipment and infrastructure, there needs to be a balance kept on increasing inputs.
- Interventions with externalities or public goods should have a priority on any additional funds.

- Targets and indicators for the sector need to include an equity and gender dimension.
- There is need to review and amend the legislation guiding health.
- There is need to clarify the functions, roles and responsibilities of all organisational structures following devolution.
- There is an urgent need to build capacity for financial management at all levels, especially at the district level.
- Conditions of service for health workers needs to be addressed, especially the contracting and absorbing of trained staff and the improving of staff housing and living conditions.
- Ability to finance recurrent cost of infrastructure and to ensure utilisation of facilities are criteria that should be considered in investing in new facilities or to maintain existing facilities.
- There is need to strengthen and formalise the coordination arrangements between the MOHS and partners in the sector through the development of a general code of conduct and/or a memorandum of understanding.
- There is need to ensure that the emerging governance structures, as part of the devolution process, are representative of the community and encourage popular participation.

1. INTRODUCTION

History of the health sector in Sierra Leone

“Underdevelopment is the degree of disequilibrium created by the introduction or imposition of one culture upon another” (Walter Rodney)

1.1 The colonisation of Africa and the imposition of western value systems alien to those of the Sierra Leone cultural inventory created certain disequilibrium which became a measure of underdevelopment. Traditional systems evolved a relatively efficient technology and social organisation to exploit the environment. This technology was available to all members. Its failure to reduce the high mortality was countered by high values attached to fertility and the social mechanism inducing it such as polygamy, early marriage and child spacing and limited traditional family planning. The traditional systems had never had to cope with the problems of human numbers outstripping resources. In these systems, there was a balance between the external environment, technology, and the internal social organisation. In short it was a closed system.

1.2 One aspect of Westernisation was that it did not succeed in its essential task of providing food and shelter for every body. The traditional system at least precluded economic and social destitution by means of the social organisation of communal living and the extended family system. The elderly, the needy, and orphans were looked after by the clan through real or fictitious kinship. The evening communal meal meant more than a social gathering. It enabled every member to have a square meal a day. The critical resource land was owned by the clan, individual families exercised rights according to certain principles of land allocation. In short enough land was available for all and there was agricultural surplus since needs were minimal. With modernisation and the monetarisation of the environmental economy food production suffered enormously.

1.3 The discovery of diamonds, bauxite, rutile, iron ore, gold and their exploitation alienated land once used for agriculture. In addition, the slicing of lands for motor roads, forest and games reserves, crown lands, European and African reservations meant less land for agriculture using the traditional methods of shifting cultivation and a rising population. Introduction of mechanised farming was never done. As a result, hunger and starvation was unavoidable and with it malnutrition.

1.4 The fate of the people and their children is that of slow starvation between April and August. The harvesting takes place from November to December and by April most of the food has run out except the seeds for planting. The next harvest of millet is not expected until August or September. At this vulnerable period, the children die in their hundreds, slaughtered by the interaction of disease, poverty, ignorance and malnutrition and poor health care.

History of the sector: Pre-conflict period

1.5 This goes back to the founding of Freetown in 1792. The new community of settlers was surrounded by hostile indigenous people and had to be protected by a garrison, and the doctoring of the population had for a long period to be done by the Military Medical Corps. The earliest hospital buildings were wooden and were based at Mabella Point while another was constructed at Falconbridge Point. A Church Missionary Society was housed at a Military Hospital that was founded in 1827. A great Military Barracks was built at Tower Hill in 1854. It was in this hospital that in 1899 that Sir Ronald Ross did most of his important work on malaria, a disease that is still responsible for the greatest disease burden today.

1.6 A Liberated African hospital was built at the King's Yard in 1820 at a point where the historic gate still stands at the entrance of the eye clinic at Wallace Johnson Street. This hospital was later renamed Connaught Hospital in honour of the visit of the Duke of Connaught in 1910. A Mission Hospital was constructed at Fourah Bay Road in 1892 and is now known as the Princess Christian Maternity hospital.

1.7 The protectorate (Provinces) was declared in the hinterlands in 1896 but the first hospital was only built in 1927 in Bo. This was followed by Makeni in 1929, and then Port Loko in 1937. Under the colonial rule, 21 hospitals were built, 7 mission, 4 mining companies and 9 Private hospital that constituted the 41 hospitals that served the whole country before the conflict.

1.8 One of the benefits of colonisation, we can grudgingly agree is the introduction of Western medicine which has made an incredible difference in the survival rates of the Sierra Leone peoples. In fact, the rapid growth of the Sierra Leone population began during the colonial period. The Population in 1965 was 1,600,000, in 1974 it was 2,749,315 and in 1985 when the last census was done it was 3.5 million and in 1994 it was projected at 4,500,000 and is growing at the rate of 2.6% per year.

1.9 The health care system was put in place very much as it was fashioned by Aneurin Bevan in the British Welfare State, soon after the Second World War. As a Socialist he looked upon health as one of the privileges the rich had enjoyed and must now be made freely available to every member of the British society. This gave birth to the National Health Services, and was immediately transported to all Anglophone countries. Sierra Leone was one of the beneficiaries of a free health service. The question of who paid for the services was never given a thought until after Independence in 1961. Medicine in those days was mostly curative. Things began to change in the early eighties.

1.10 A Sierra Leonean, Dr Marcella Davies proclaimed at Alma-Ata in 1978, the concept Primary Health Care when a date was chosen as both a target and a mobilising slogan for achieving health for all (HFA) by the year 2000. This was to be achieved through universal implementation of PHC. The Declaration of Alma-Ata devised a new prospect for human development where people empowered by knowledge and skills became responsible for their own health and development. The dream of those who met at Alma-Ata - politicians, health professionals, managers, economists and planners - was to see within a reasonable period - thirty years - the rise of a new world where all populations enjoyed better health and greater social equity. The Ministry of Health embarked upon a frantic effort to implement PHC along the line of HFA by the year 2000. Dr Marcella Davies was then our Chief Medical Officer.

1.11 The Government of Sierra Leone (GOSL), a signatory to the declaration, embraced PHC and its implementation as a core policy for the health care of the peoples of Sierra Leone. The Ministry of Health adopted as part of its strategy to implement PHC the establishment of Peripheral Health Units (PHUs) in all districts in the country. About 500 PHUs were constructed throughout the country. There were three types of them differing by the level of staffing, equipment and size of the population served:

- Community Health Centre (CHC), focusing on health care in the chiefdom, situated in chiefdom headquarters.
- Community Health Post (CHP).
- Maternal and Child Health Post (MCHP).

1.12 By 1990 the Ministry had almost reached its target of 500 PHUs countrywide in line with its strategy, table 1.1 shows the number of PHUs and hospitals functional per province at that time.

Table 1.1: Health Facilities in PMISU/MOH 1990

Area	Population	PHUs	Hospitals
Eastern Province	961,000	161	18
Northern Province	1,260,000	165	14
Southern Province	741,000	127	10
Western Province	554,000	26	16
SIERRA LEONE	3,516,000	479	58 (GOSL 23)

Source: National Primary Health Care Handbook, 1990

Conflict period

1.13 James Baldwin in his book *The Fire Next Time* said “the worst creation of any society is a man or woman who has nothing to lose”. The Revolutionary United Front (RUF) was the worst creation Sierra Leone ever made of men and women who felt they had no future under the then existing political system. They felt they were suffering from a living death. They blamed the then prevailing inadequacies to the poor management of the economy which they felt, was being sucked dry by robber-elite who ruled from the capital and made deals with foreign countries and companies.

1.14 A rebellion aimed at overthrowing the government in power started in the bush in 1991. The war enabled the youth to live by the gun and live better. They discovered that looting was more profitable than waiting half educated for a job that will never come. Within six years of rebel activity, the state died, its authority morally and physically destroyed along with its looted and burnt out offices, houses and above all PHUs in all the provinces. By 1995, only 16% of the PHUs were functioning. Things did start to improve, even during unrest, and gradually by July 1996, 47.8% of PHUs were functioning, rising to over half (51.4%) in September 1996 (UNICEF, 1996). The main reason was the willingness of the health workers and the community support. In fact by the end of 1996 a total of 659 PHUs were listed from all the districts, and over half of them 339 (51.4%) were functioning.

Transition period

1.15 The problems of transition from a ten-years conflict when much of the country was devastated; over 3000 villages, health care and educational facilities destroyed, into a country with a buoyant economy and functioning health infrastructures, are formidable. The country has hardly started the health transition as shown by the appalling health indicators. It is now two years since the end of hostilities and four years since the adoption of the Millennium Development Goals. The Millennium declaration included a set of targets for development and poverty eradication. In effect the targets covered areas of extreme poverty, safe water, primary education, food security, malaria, HIV/AIDS, maternal mortality, and other major diseases.

1.16 The clinical syndrome of a sick health system and therefore ineffective health services delivery is evident for all to see: Many health centres, general hospitals and specialised institutions are in a state of disrepair or completely vandalised. Hospital beds are old and uncomfortable, bed linen a luxury. The toilets are non-functioning, instruments barely exist or rusty. The women deliver their babies in poor conditions, essential drug supply inadequate so pharmacies are empty. Patients admitted for surgery are expected to bring their surgical materials, relatives must donate blood and reagents for screen may not always be available. Many health staff are demotivated; some have lost their basic skills through disuse or absence of refresher courses. The moral is low for many and so quality of care has suffered. All hospitals have inadequate budgets and this has led to the exodus of highly trained staff. Health professional

associations have unwittingly become trade unions fighting for better conditions for themselves, better equipment and facilities and only rarely for higher professional standards. This has further complicated the administration of health care.

1.17 The epidemiological picture now in Sierra Leone is characterised by a high incidence of communicable diseases such as malaria, respiratory diseases, and water borne diseases such as cholera. Transition has to take place through certain overlapping historic epidemiological phases that all human societies go through:

- Health related environmental conditions. Prevalence of recurrent and endemic infectious diseases, and malnutrition. Various diseases associated with water: those transmitted directly by biological or chemical agents through water .e.g cholera, viral hepatitis, amoebiasis and typhoid fever. Those due to inadequate hygiene because of lack of water e.g. scabies. Those caused by direct contact with water such as schistosomiasis; and those caused by vectors living in water e.g. malaria, and onchocerciasis.
- Health related life -styles-tobacco, alcohol, drugs and STI/HIV/AIDS
- Health-related population factors include: rapid population growth, changes in the age structure, male/female disparities, rural urban migration. vulnerable groups; displaced persons, refugees; famine or hunger, drought and the growth of cities

1.18 Enormous resources will be required, some beyond the country's ability to provide to address these growing health problems. Efforts are ongoing though and with good planning much can be achieved. At the moment, much of the debate about improving the health services is centred on the question of decentralisation. A lot of progress has been made. Hospital boards have been established for all the districts and it is hoped that this will give the rural people more say in the health needs of the community. District Council elections will be held in May 2004 and when fully functional the Councils will provide supervision and surveillance to the District health boards. In conjunction the role of Village and Community Development Committees in the local participation and management of health activities is being strengthened. All these efforts will go to ensure a future where Sierra Leoneans feel greater control of their own health.

2. Health and Poverty

2.1 Poverty reduction is a central policy objective of the Government of Sierra Leone (GOSL). The Government finalized its Interim Poverty Reduction Strategy Paper (I-PRSP) in 2002, the approval of which allowed Sierra Leone to qualify for debt relief under the World Bank Highly Indebted Poor Countries Initiative (HIPC). Human capital development is key to poverty reduction, this means promoting a healthy population so that people can lift themselves out of poverty and increase productivity.

2.2 Health issues were highly identified in the non-income aspects of poverty in Sierra Leone in the I-PRSP, in particular the burden of the high incidence of Malaria, especially in the North of the country. In both the Transition and Medium-term phases of the poverty reduction strategy health is prominent under the social programmes and health is core under three of the five pillars which form the bases for developing the full-PRSP.

2.3 This chapter sets out the poverty profile in relation to health in Sierra Leone using available data, mainly data from the Sierra Leone Integrated Household Living Conditions Survey (SLIHLCs, 2004). Poverty in Sierra Leone is widespread, deep and severe. With over half of the population (57%) of the country deemed to be poor, unable to meet their basic daily nutritional needs, living on less than \$1 a day (UNDP 2001). Poverty is worse in the rural areas and the Eastern Province is the poorest of the four provinces, the poorest districts in the country being Kailahun, Bonthe and Tonkolili.

Table 2.1: Situation of Poverty in Sierra Leone.

Level of Poverty	District
5% living below the poverty line	Western Area- Urban
= 50% living below the poverty line	Moyamba, Pujehun
50-70% living below the poverty line	Bo, Kambia
>70% living below the poverty line, <75% food poverty	Koinadugu, Port Loko, Tonkolili
>75% severe food poverty	Bombali, Kenema, Kailahun
Highest Gini coefficient of inequality: 0.36	Kono

Source: Sierra Leone Integrated Household Living Conditions Survey 2004, preliminary results

Characteristics of the poor

2.4 Income and consumption inequality in Sierra Leone is great, with the poorest 20% of the population consuming only 7% of total goods and services, whilst the richest 20% consumes 46%. Consumption is also more unequally distributed between the more urbanised Western Area and the rural districts, with 19% of the per capita consumption by district attributable to the Western Area while all other districts' consumption range from 5-10%, average being 6.75%.

2.5 There are more women living in poverty in Sierra Leone than men, 69% of female headed households are poor against 59% of male headed households. For every 100 women living in lowest poverty quintile in Sierra Leone there are 93 men. Poor households are considerably larger, have more women and dependents-per-worker than non-poor households. There are a growing number of households in Sierra Leone headed by women, and these households are disproportionately poor. Far fewer households are headed by women in the urban areas. Women tend to have lower education, (90% of mothers in the lowest quintile had not completed primary education), limited access to productive resources, a narrower range of formal sector labour market opportunities, and lower wage rates than men. Furthermore, they are weighed down by social, parental and marital obligations, which reduce their opportunities and the flexibility to move upwards even if they so desire.

2.6 Levels of education in Sierra Leone are generally low, 30% of the population over age 15 years are literate, (females 19%, males 31%, UNDP 2001). Forty-two percent of children of primary school age in Sierra Leone are attending primary school, attendance in the North and East is lower at 28 and 35% respectively (MICS2 2000). Only about 38% of girls are enrolled in schools compared to 52% of boys and women are less likely to have attained higher levels of education than men.

Causes of poverty

2.7 The key causes of poverty been identified as limited access to land, failing business sector, inability to produce food for consumption and income, low education, poor health status, inability to work or participate in incoming generating activities, poor environmental sanitation, loss of property during the war and a lack of access to financing and credit (PPA 2003 & 2004, SLIHLCS 2004). These impact on food security, which often translates into problems of malnutrition. Food dominates expenditure of all households, particularly in the rural areas, accounting for almost 44% of total household expenditure.

2.8 Ill-health and access to health care is central to people's analysis of poverty. Hunger, poor health facilities and diseases, in particular water-borne and communicable diseases, are amongst the greatest burden. The poor were said to suffer most from diseases because of having poor access to sanitation, safe water, poor housing, lack of nutritious food, lack of money to pay for health care or pay for transport to health facilities (PPA 2003 & 2004). In general, although health facilities are recognised as important institutions in people's lives, there is a general perception that the quality of services had declined and people view a further decline in the quality of health care since the NGOs withdrew from direct health care provision following peace in Sierra Leone. This decline in services is something that Government has also identified as an issue and is eager to redress the situation.

2.9 The poorest of the poor are more likely to be living in female-headed households. Most of women's working hours are spent on household chores, predominantly food production and food security, water collection and gathering firewood. It is estimated that 54% of households obtain their water from a safe source, 74% urban and 46% in rural areas, with the North having the lowest access at 30% (MICS2 2000). Childcare and caring responsibilities for the sick are also carried out predominantly by women and girls within the household. Gender differences in men's and women's roles and responsibilities, and gender inequities in access to resources, information and power have an impact on women's health.

Health outcomes/indicators and poverty

2.10 The extent of poverty in Sierra Leone is reflected in its' poor national and regional health and socio-economic indicators, see tables 2.2 and 2.3 below. Life expectancy at birth has dropped to 34.5 years in 2001 down from 42 years in 1990. In 2001, infant and under-five mortality rates were estimated to be 182 and 316 deaths per 1,000 live births, showing marginal decreases from 185 and 323 respectively from 1990. This means that almost one Sierra Leonean child in three will die before their fifth birthday. Childhood mortality rates are linked to indicators of poverty, with urban mortality rates being lower than rural rates and high rates corresponding to low levels of mother's education.

2.11 The maternal mortality rate in 2000 was estimated at 1,800 deaths per 100,000 live births. Reasons for this have been documented in many reports and studies, both clinical and non-clinical causes of maternal death. Clinical causes of death mainly being complications of pregnancy and childbirth such as haemorrhage, anaemia, eclampsia, obstructed labour, and unsafe abortion: non-clinical reasons are related to delays in decision making about seeking medical care, delays in reaching the health care facility, and delays in receiving prompt and appropriate care at the health facility. The low status of women in households and the community in general and their limited access to resources particularly in times of emergency contribute to the barriers in seeking health care. Rural women with no education are more likely to be pregnant or to ever have been pregnant. See chapter 4 for further discussion.

Table 2.2: Demographic and other health indicators

Population (Estimated)	5,200,000
Crude Birth Rate	42/1000
Crude Death Rate	19/1000
Infant Mortality Rate	170/1000
Under five mortality rate	286/1000
Maternal mortality rate	1,800/100,000 per live births
Life Expectancy at birth	42 years
Average completed fertility	5.9 births/woman
Total Fertility rate (per woman) 2000-2005	6.5
Contraceptive prevalence rate (%), 1995-2001	4
Disability prevalence	7.0 per thousand
Underweight prevalence	27.2%
Stunting prevalence	33.9%
Prevalence of HIV	0.9%*
Access to health services	40%
Access to safe water	54%
Access to sanitation	20%
Literacy rate – female	19%

Source: MOHS Statistical Information Sheet 1 July 2002. *HIV/AIDS Seroprevalence and Behavioural Risk Factor Survey in Sierra Leone April 2002 (Final Report)

2.12 Fertility rates remain high, estimated at 6.5 for women for 2000-2005. High fertility rates are closely related to rural residence and low socio-economic status, with age at first childbirth being low. Contraceptive prevalence rate also remains low at 4%, in the household survey 5.6% of respondents reported that they were doing something to prevent pregnancy, preferred method being pill, 48.1% following by injectables, 25.9%.

2.13 Children in Sierra Leone are generally malnourished. In 2000, 27% of children under age 5 were found to be underweight or too thin for their age while 34% were stunted or too short for their age and 10% were wasted or too thin for their height (MISC2 2000). Again, the links between malnutrition and poverty are evident. Children in rural areas are more likely to be stunted and wasted than children in urban areas. Similarly children of mothers with no education are more likely to be underweight than children of women with some education.

Table 2.3: Regional Health and Socio-economic Indicators.

	Sierra Leone	Liberia	Guinea	Mali	Gambia	Senegal	Côte d'Ivoire
Life expectancy at birth (years), 2001	34.5	41.5	48.5	48.4	53.7	52.3	41.7
Adult literacy rate (% age 15 and above), 2001	36.0	54.8	41.0	26.4	37.8	38.3	49.7
Population living below \$1 a day (%), 1990-2001	57.0	n/a	n/a	72.8	59.3	26.3	12.3
Population living below \$2 a day (%), 1990-2001	74.5	n/a	n/a	90.6	82.9	67.8	49.4
GDP per Capita (US\$), 2001	146	163	394	239	291	476	634
Total population (millions), 2001	4.6	3.1	8.2	12.3	1.4	9.6	16.1
Annual population growth rate (%), 2000-2015	2.4	3	2.2	3.1	2.3	2.2	1.5
Urban population (as % of total), 2001	37.3	45.5	27.9	30.8	31.2	48.1	44.0
Total fertility rate (per woman), 2000-05	6.5	6.8	5.8	7.0	4.7	5.0	4.7
Population with access to improved sanitation (%), 2000	66	n/a	58	69	37	70	52
Population with sustainable access to an improved water source (%), 2000	57	n/a	48	65	62	78	81
One-year-olds fully immunized against tuberculosis (%), 2001	74	77	71	68	99	89	72
One-year-olds fully immunized against measles (%), 2001	37	78	52	37	90	48	61
Contraceptive prevalence rate (%), 1995-2001	4	n/a	6	8	10	13	15
Births attended by skilled health personnel (%), 1995-2001	42	51	35	24	51	51	47
Physicians (per 100,000 people), 1990-2002	9	2	13	5	4	10	9
Public health expenditure (as % of GDP), 2000	2.0	n/a	1.9	2.2	3.0	2.6	1.0
Private health expenditure (as % of GDP), 2000	1.7	n/a	1.4	2.7	0.6	2.0	1.8
Health expenditure per capita (PPP US\$), 2000	24	n/a	56	32	51	56	45
Undernourished people (as % of total population), 1998/2000	47	39	32	20	21	25	15
Tuberculosis cases (per 100,000 people), 2001	258	176	134	295	283	103	207
Infant mortality rate (per 1,000 live births), 2001	182	157	109	141	91	79	102
Under-five mortality rate (per 1,000 live births), 2001	316	235	169	231	126	138	175
Maternal mortality ratio reported (per 100,000 live births), 1985-2001	1,800	580	530	580	n/a	560	600
Adult HIV Prevalence, 2003	0.9*	8.2	2.8	n/a	n/a	n/a	5.8**

Source: www.undp.org/hdr2003/indicator

n/a = not available, * Source: HIV/AIDS Seroprevalence and Behavioural Risk Factor Survey in Sierra Leone April 2002 (Final Report) , ** 1998 Data

2.14 Availability of clean water and safe sanitation is a major factor affecting the health status of the population. More than one third of the population still do not have access to safe drinking water, and 66% have access to improved sanitation facilities. Lack of sectoral coordination is one of the main obstacles to promoting equitable access to safe water and sanitation. There are major issues over responsibility for sanitation particularly urban solid waste. This is further discussed in Chapter 11 and hygiene promotion is generally weak in the districts due to resource constraints.

2.15 The majority of the causes of illness and death in Sierra Leone are preventable, see Fig 2.1 below. The majority of in-patient deaths are reported to be due to nutritional deficiencies, pneumonia, anaemia, malaria, tuberculosis and now HIV/AIDS. Diarrhoeal diseases and acute respiratory infections are also major causes of out-patient attendance and illness in the country. The greatest burden of disease is on rural populations, and on females within the rural population. Women are also more likely to have to stop their activities due to illness than men, 53.1% of those having to stop work due to illness in the previous two weeks being women. Immunisation rates are generally high, of the 4% of respondents reporting never been vaccinated over 90% of the mothers had no formal or never completed primary education and are more likely to be rural, 70.1%. The main reason for not vaccinating given was "did not know vaccine necessary", 35%, followed by 24.3% reporting that the reason was that the "health centre too far". A quarter of people (24.9%) paid for vaccinations and it was most likely to be in a government health facility (89.3%), paying approximately Le.500 (US\$0.20) on average. Although the MOHS policy is to give priority to interventions that target preventable diseases, which cause a high disease burden on the poor and most vulnerable, the experience is that people are prevented from getting one disease and because of their poverty they are then exposed to yet another disease.

Fig 2.1: Current national priority health problems¹:

- Malaria
- Sexually transmitted infections including HIV/AIDS
- TB
- Unsatisfactory reproductive health including maternal and neo-natal mortality
- Acute respiratory infections
- Childhood immunisable diseases
- Nutrition-related disease
- Water, food and sanitation-borne diseases
- Disability
- Mental illness

Source: Ministry of Health and Sanitation, National Health Policy 2002 (Draft)

2.16 Malaria accounts for the greatest disease burden in Sierra Leone. Malaria is the leading cause of morbidity and mortality, accounting for over one third of all out-patient visits. During the district consultations for this review it was reported as the top cause of illness in all districts. In the recent household survey of those people that were sick in the past year, malaria was the illness suffered most, 39.3%, with women reporting slightly

¹ National health priorities have been set on the basis of a number of criteria. These are:

- The severity of the disease in terms of its contribution to the overall burden of disease in the country
- The distribution of the health problem within the country as a national problem
- The feasibility and cost effectiveness of interventions concerning the health problem
- Public expectations concerning the problem
- Compliance with international regulations

higher rates than men, 52.1% versus 47.9%. In the Public Expenditure Tracking Survey (PETS), done in 2002, only 14.2 of facilities reported having Insecticide Treated bed-nets (ITNs) available for distribution. During this review it was found that although ITNs are now available in most districts and PHUs they are not in high demand. This can be attributed to both the cost of the bed-nets, average sale price reported as Le.5,000 (US\$2) and the failure of health promotion activities to stimulate demand. Although ITNs are available the overall supply is very small if demand was to take off. Currently ITN use is fragmented and is having no real impact on reducing morbidity or mortality on malaria. International experience shows that to achieve any impact on the malaria disease burden through the use of ITNs there needs to be a high penetration of ITN usage, complemented with good health education, environmental improvements and systems in place to re-insecticide the bed-nets on an ongoing basis. The current scattering of ITNs will have limited impact on the problem.

2.17 The distribution of resources for health is discussed in subsequent chapters, they show that although MOHS does place a priority on allocating the funds available to primary health care (PHC) and district level activities (35.2% and 29.1% respectively in the 2004 budget) there is a serious problem with the overall level of funding available and its ability, even if effectively used, to have an impact on the burden of diseases. The MOHS has well established disease programmes, many with their own specific technical policies and cost effective strategies, but their ability to delivery any real impact is severely curtailed due to overall lack of resources; financial, human and supplies. The MOHS does a three-year strategic rolling plan and identifies the possible financial resources available for the next three years; the current plan is from 2004-2006. This plan shows that there is a funding gap of approximately 30% of the total budget needed to run the public health programmes over the next three years and 70% of the funding gap is in the areas of primary and secondary health care, the levels of health care most utilized by the poor.

Impact of HIV/AIDS

2.18 The HIV/AIDS epidemic poses a particularly serious challenge for Sierra Leone. The estimated national prevalence of HIV, 2002 survey, is 0.9%², with Freetown having 2.1% and outside of Freetown 0.7%. Neighbouring countries to Sierra Leone have a growing problem also with estimated adult HIV prevalence of 8.2% in Liberia, 2.8% in Guinea and 5.8% in Côte d'Ivoire. The most affected groups in Sierra Leone are women with a prevalence rate of 1.3% and youth aged 15-24 years with 0.8%. A recent antenatal clinic sentinel surveillance among pregnant women in eight sentinel sites gave a national prevalence of 3.4% and a prevalence of 4.7% in Freetown (Antenatal Clinic Sentinel Surveillance 2004). Knowledge on HIV is increasing, a study in 2000 found only 54% of women aged 15-49 had heard of HIV/AIDS compared with the PETS Health Services Delivery survey 2002 which found awareness rate of HIV/AIDS over 90%, though knowledge and awareness has increased it was still reported by health workers during this review that people do not still believe that HIV is real and health workers interviewed reported having seen a few or no patients with HIV. There are limited HIV testing facilities outside of Freetown and testing is mainly limited to major government hospitals including blood screening of transfusions where possible.

2.19 However, the increasing prevalence of HIV will lead to increased TB and other Opportunistic Infections and an overall increased disease burden. HIV/AIDS will have an impact on all aspects of life in Sierra Leone: on individuals and their families; businesses

² Preliminary results from the 2002 sentinel surveillance survey gave a prevalence of 4.9%, however the final results gave a prevalence of 0.9%, it is understood that CDC are doing a quality assessment of the survey to authenticate the final results.

and organisations; and, finally, on the macro-economy. At the household level, resources are diminished by loss of earnings of the person who is ill (often the main breadwinner), costs of accessing health care, other household members' time used in caring for the sick person (usually time of women and girls), and the direct costs of death in the family (funeral expenses, loss of land.) These often lead to the inability to pay for school fees, and therefore reduction in future earning capacity. Often, death of adults and parents also leaves a huge demand on remaining family members to care for orphans. Increasingly, extended families are unable to meet these demands, leaving orphans to fend for themselves or head households of their siblings. The impact of HIV/AIDS in agriculture is felt in the loss of labour through illness and death. In addition to biological differences in vulnerability to HIV infection and illness amongst men and women, gender relations also influence vulnerability to and impact of HIV/AIDS at household level. Similarly, the burden of care for HIV/AIDS at both household and community levels is borne primarily by women and girls.

2.20 The public service, NGOs and the private sector all experience a loss in productivity and increased costs caused by absenteeism due to illness or attendance at funerals, medical bills, funeral costs and payment of premature death benefits. Attrition rates due to HIV/AIDS will increase. In the long-term this will impact on the ability to recruit skilled labour at all levels. There have been no studies to date to quantify the impact on the health sector, both through the loss of qualified and experienced personnel and the impact of HIV/AIDS illness on health services. In terms of human resources, early death caused by HIV/AIDS contributes to the attrition of staff in the health sector plus stigma and fears of occupational health risk will reduce the quality of care provided to those infected, and as care outcomes become less positive then the health care working environment becomes less attractive for staff, resulting in a decrease in numbers entering training institutions.

2.21 Recommendation

- Additional resources need to be made available to fight the most common diseases, ensuring that prevention strategies are prioritised.

3. Equity and Health Care

3.1 The basic definition of equity in health is “each according to their needs”. This simple definition implies that some have greater needs than others. Equity therefore must not be confused with equality which means all are the same. Equity is at the basis of improvement in health for those that are most in need. Ill-health is not only caused by poverty but is a cause of poverty. Illness exacerbates poverty through lost productivity of the person who is ill and the person(s) providing care in the household, usually women. Accessing health care also poses a significant burden on poor households.

3.2 The draft National Health Policy, 2002, emphasises the MOHS’s role for ensuring an equitable financing and resource allocation system for the health sector. Structures comprising relevant stakeholders have been established to facilitate oversight at both district and national levels (DHMTs, Hospital Boards and Management Committees, Budget Oversight Committee).

3.3 There are major differences in the allocation of public funds and personnel among the various districts. The more urban and wealthier Western Area and Bo District have about three times as many personnel per head of population as the more rural districts of Moyamba, Kono and Kailahun, which also have poorer access to private sector providers. The distribution of personnel indicates that there is a general scarcity of health care personnel to serve the poor and people in rural areas.

3.4 The allocation of MOHS recurrent budget for 2004, and subsequent years, has given preference to primary health care (35.2%) followed by complementary secondary care (29.1%) and tertiary care (14.6%), see table 3.1 below. Lack of facilities and resources have resulted in a weakened tertiary care worthy of note. In addition, there has been a reduction in the allocation of resources for administration since 1999. In view of the scarce resources available, this is an efficient practice. However, attention should be given to the necessary balance between complementary primary and secondary care at district level, and future allocations should ensure that funds are not used to build up tertiary care at the expense of primary and secondary care at district level.

Table 3.1: Programme Budget allocations MOHS 2004-2006

PROGRAMME	Actual Annual Allocation 2004 (Le'000')	% Allocations	Indicative Estimates 2005 (Le'000')	% Estimate	Indicative Estimates 2006 (Le'000')	% Estimate
Administration	2,482,030	6.9	2,947,138	7.0	3,335,128	7.0
Human Resources Management	2,033,238	5.6	2,419,466	5.8	2,737,987	5.8
Support Services	3,089,799	8.5	3,676,730	8.7	4,160,769	8.7
Tertiary Health Care Services	5,278,050	14.6	6,280,657	14.9	7,107,504	14.9
Secondary Health Care Services	10,537,080	29.1	12,538,679	29.8	14,189,393	29.8
Primary Health Care ³	5,141,324	14.2	5,119,583	12.2	5,793,574	12.2
District PHC Services	7,598,490	21.0	9,041,882	21.5	10,232,241	21.5
TOTAL	36,160,011	100	42,024,135	100	47,556,596	100

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

3.5 Analysis of the health expenditure done as part of the public expenditure review in 2002 reported that the reviewed budget and indicative estimates for the next three years for health would maintain the status quo in most instances. It would only marginally

³ This Primary Health Care programme is planned and managed at national level, a large part of this budget should pass to the District PHC Services programme under decentralisation.

increase the level of MOHS recurrent expenditure and diminish its proportion to only 5.8% of the Government's recurrent expenditure (less interest) by 2004. This would keep personnel expenses even lower at 25% of the total in 2004 in comparison with 30% in 2001. It would improve the balance between primary and secondary care over the three-year period, but it would not change the substantial differences between the wealthier urban and the poorer rural areas. Further it would increase even further the disparity between capital and operating expenditures, to a point where capital expenditure will grow more rapidly than operating expenditures. It would also increase further the dependency on external funding, that in 2004 would account for 52% of funds for all MOHS purposes. This drastic increase in capital expenditure needs to be considered in light of the construction and rehabilitations of facilities to get the stock back to pre-war levels, but must be closely monitored for future recurrent resource requirements.

3.6 It is also important to monitor the per-capita expenditure per district on health. Table 3.2 below shows a wide discrepancy in the per capita recurrent budget on health across districts, ranging from Le.2, 666.38 in Moyamba to Le.9,135.22 in the Western Area. It can be argued that some of the Western Area budget goes to national referral hospitals; however it is a general experience that referrals do not work very well even within districts and are very poor nationally so the budget for these hospitals can be argued to be mostly addressing the needs of their district's population.

Table 3.2: MOHS PHC and Hospital Budgets by district Population 2004

District	Budget 2004 Le. ('000)	District Population (a)	Per Capita Expenditure Le.
Bo	2,434,560	552,500	4,406.44
Moyamba	991,893	372,000	2,666.38
Pujehun	896,793	229,000	3,916.13
Bonthe	1,141,200	183,000	6,236.07
Kenema	2,187,300	490,500	4,459.33
Kailahun	991,893	294,000	3,373.79
Kono	1,189,701	353,500	3,365.49
Bombali	1,046,100	390,000	2,682.31
Port Loko	1,759,350	509,500	3,453.09
Tonkolili	1,378,950	395,000	3,491.01
Koinadugu	951,000	232,500	4,090.32
Kambia	1,027,080	231,500	4,436.63
Western Area	7,417,800	812,000	9,135.22
Total	23,413,620	5,045,000	

(a) Population projections by Statistics Sierra Leone for Census 2004,
Source: Directorate Planning and Information, Ministry of Health and Sanitation

Availability of health services

3.7 In Sierra Leone, as in other low-income countries, the health sector is characterised by a plurality of health service providers. MOHS accounts for approximately 70% of the total number of 'formal' or allopathic health facilities, followed by church providers (20%). Other formal health service providers include municipalities, Police, Army, companies/firms, NGOs and private-for-profit. The scale of the traditional health sector (traditional healers) is unknown. It is reported that almost three quarters of deliveries are attended by a Traditional Birth Attendants (TBAs) and it is known that most communities have a traditional healer. Other sources of care include over the counter sales of drugs in grocery stores and pharmacies, and to a lesser extent community based agents exist for family planning commodities, community volunteers, home based care volunteers

and faith healing groups, there is a growing trend in the existence of 'peppe doctors' or 'quacks' in rural communities, further discussed in chapter 13.

3.8 General accessibility to health facilities shows considerable district variations. Qualitative perceptions from rural communities reveal that physical distance to health facilities presents a major barrier to access to care. The problem is exacerbated for pregnant women or the very sick who cannot walk. In these cases people have to hire commercial vehicles and in many rural areas commercial vehicles for hire may not be available or affordable.

3.9 Geographical access does not take into account the quality of services (level of facility, communications, staff and drug availability or user-defined aspects of 'quality'), seasonal accessibility, or the referral accessibility of peripheral health units (PHUs) to the district hospital. In terms of staff, numbers of health personnel per head of population per district show large differences, with an over concentration of the more skilled workers in the Western Area. Table 3.3 below shows the distribution by province of PHUs.

Table 3.3: Distribution of PHUs pre and post-war

Province	No. of PHUs pre-war (1990)	No. of PHUs post-war (2003)
Eastern	208	164
Northern	262	260
Southern	198	144
Western Area	62	33
Total	730	601

Source: Presentation by Minister of Health and Sanitation, December 2003

3.10 The availability of drugs at peripheral health units is poor in terms of quantity, range of drugs and price. A major complaint being that the prices of drugs in the public health system are higher than in the private sector. The drug supply system is discussed in greater detail in chapter 10.

3.11 Although geographical health service coverage is 'reasonable' in Sierra Leone, evidence suggests that this does not ensure accessibility, as service delivery is dependent on availability of health care providers and the skills of those providers. Large variations exist in the distribution of staff and therefore the availability of services through out the country. Table 3.4 below shows the situation as of December 2003.

3.12 The distribution of MOHS health care workers shows large differences in the number of people per staff among the districts ranging from 1:699 people to 1: 6,255. The WHO recommended doctor to population ratio for developing countries is 1:12,000, as can be seen in the table below only the Western Area meets this target, with the doctor to population ratio for Kailahun district being 25 times this recommended level. There are only 13 Pharmacists in the country and 12 work in the Western Area. Lack of suitably trained staff greatly contributes to poor service delivery and in the case of drugs and medical supplies totally undermines the drug supply system. The distribution of the numbers of health workers per head of population favours the wealthier Western Area and Bo and Kenema districts and it is at its lowest levels in the apparently poorer districts of Kono, Moyamba, Tonkolili, Port Loko and Kailahun. This could be considered an inequitable distribution of public resources and funding.

Table 3.4: Health Care Delivery Personnel Employed by District: December 2003

District	Population per health care delivery worker				District Population (c)
	Health Care Delivery Worker (a)	Doctor	Doctor & CHO (b)	Qual. Nurse, Midwife & MCH Aide	
Western Area	699	10,025	7,315	962	812,000
Bo	2,175	61,389	16,250	3,348	552,500
Kenema	2,370	54,500	18,167	3,292	490,500
Pujehun	3,881	114,500	38,167	5,204	229,000
Kambia	2,853	115,750	28,937	4,630	231,500
Bonthe	3,735	183,000	22,875	5,545	183,000
Bombali	3,824	195,000	55,714	4,643	390,000
Koinadugu	3,185	232,500	77,500	4,305	232,500
Moyamba	3,477	186,000	33,818	4,593	372,000
Kono	4,159	117,833	32,136	6,312	353,500
Tonkolili	4,489	197,500	79,000	5,724	395,000
Port Loko	5,045	169,833	46,318	6,885	509,500
Kailahun	6,255	294,000	36,750	9,484	294,000
All Districts	2,099	42,754	20,180	3,032	5,045,000

Note: (a) Includes all health care delivery workers, both skilled and assistants. (b) CHO Community Health Officer. (c) These district populations are based on the Statistics Sierra Leone's projections for districts for the Census 2004. Sources: Department Planning and Information, Ministry of Health and Sanitation, Statistics Sierra Leone Census 2004.


Utilisation of health services

3.13 General population utilisation rates of health facilities in Sierra Leone is estimated at 0.5 contacts per capita per annum, this means that half the population attend a health facility once each year. By international standards this is a low utilisation rate and begs further understanding of the supply and demand for health care in Sierra Leone. In the recent household survey 44% of respondents reported having had an illness in the last two weeks of which 85% of those had to stop their activities as a result. Although over 80% of the total respondents that had had an illness in the previous two weeks consulted a trained health care provider by first choice only 1.2% of respondents were admitted to a health facility, mainly being admitted into a government hospital (61%), with an urban bias on admissions (56%). Only 7.5% reported using a traditional healer as first choice and 8.7% a pharmacist. Over 55% consulted a government health facility at some stage during last illness, followed by 31.8% using private facilities with just over 10% using a mission or NGO facility. 20% of women had had a pregnancy in the last 12 months, with the greater percentage being women with no formal education, 80.6% of these 88.6% attended prenatal care for those that did not attend 87.3% did not have any formal education. Of the total attendances (female, male, adult and child) to health facilities by all approximately half of the visits were for vaccinations and growth monitoring and the other half were for illness.

3.14 Social roles and expectations, and norms and values of behaviour mean that women are more vulnerable to ill health, yet have fewer resources and opportunities to protect their health or to utilise health care. Access and utilisation to health care is not only limited by economic barriers, but also social and cultural ones. Fig 3.1 below represents the coping strategy used by many women and particularly those that end in a maternal death. Given that decisions on the consumption of health are made within the household there is need for greater understanding of the decision making environment within households and a greater need to ensure that strategies to increase female utilisation of services are sufficient to address deficiencies in the household decision making process. It is important for DHMTs to identify and concern themselves with those people in their districts that are excluded from receiving health care. Immediate action

must be taken at district level to address the issue of exclusion and barriers to access, especially in the area of women's health.

Fig 3.1. Continuum of coping strategies



Delay Consultation	Seek lower fees or credit Seek alternative providers, Herbalist, Quacks	Seek Funding - Sell Property - Local Credit Schemes - Appeal to VDC/CDC	Resign oneself to ones fate	Calmly await death - "God's Grace" - "Inshala"
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Adopted from Bulletin of the World Health Organization 2003, 81 (7), p. 536

The high cost of accessing public health care

3.15 In the household survey 69.5% reported that they had paid at their last attendance at a health facility. For all attendances 50% paid Le.1,000 (US\$0.40) or more, while 10% paid Le.10,000 (US\$4) or more. Of those pregnant women that did not attend antenatal care 75% was due to cost or distance to the health care facility. Almost half of mothers attending antenatal care paid over Le.2,500 (US\$1) for their visit, 10% paid Le.7,500 (US\$3) or more and 5% paid Le.10,000 (US\$4) or more. Actual household per capita expenditure on health per district varies greatly. The national average expenditure being Le95,708 (US\$38.28), but ranging from Le.23,767 (US\$9.50) in Kailahun to Le.216,338 (US\$86.54) in Western Urban.

Table3.5: Payment by urban and rural for health care by lowest and highest quintile

	Urban		Rural	
	Lowest 20% Le.	Highest 20% Le.	Lowest 20% Le.	Highest 20% Le.
How much Paid?	1,906	7,342	1,118	6,292
How much for travel?	371	1,375	163	2,223
How much for paid for hospital?	3,500	59,720	1,263	35,314
How much paid for medicine?	2,631	15,793	2,132	6,608

Source: Preliminary results from the Sierra Leone Integrated Household Living Conditions Survey, 2004.

3.16 Within poor households, there is a gendered impact of the high cost of accessing health care. Women have less access to cash, or control over resources within the household.

3.17 It is important not to equate actual household payments with ability to pay in the context of a poor nation such as Sierra Leone. While people have demonstrated their willingness to pay in this study, it does not necessarily mean they were able to pay, neither does it tell us what was the opportunity cost of the payment nor how the expenditure was financed, i.e. borrowed money or sale of assets, etc

Quality of health care

3.18 The Public Expenditure Tracking Survey (PETS) 2002 found that 35.0% of the communities rated the quality of health services provided as satisfactory compared to 47.0% in the first PETS. In the district consultations carried out as part of this review

those members of the public interviewed expressed a satisfaction with the health workers but not with the general health care being provided, citing that it was inadequate in many ways, mainly; lack of trained and skilled staff, lack of drugs, cost of drugs, lack of equipment, lack of ambulances for referral and high user charges. There appeared to be an understanding by the public that the problems were not the making of the health workers, but rather the health care system in general.

3.19 The main measures of quality as indicated by the communities and their representatives, through different consultation processes, have been availability of drugs and trained staff, improved and increased infrastructure, and transport for referral when necessary. The MOHS is committed to addressing these issues. A major step will be the development of a comprehensive policy on human resources, which will address the deployment of staff to rural areas, the updating of skills of existing health workers while strengthening the range and numbers of staffs currently being trained, see chapter 9.

3.20 The MOHS is also in the process of reforming the Central Medical Stores, will review and update the National Drug Policy, Essential Drugs List and working with districts in the establishment of effective and efficient revolving drugs fund. Standards for the location and distribution of health facilities are being set and guiding the capital planning, while setting minimum standards for facilities and rehabilitating existing facilities to these standards. The rehabilitation and reconstruction of health facilities to reach at least pre-war levels is ongoing, there were 730 functioning Primary Health Units before the war and by 655 were recorded as functioning by 2003. Community involvement in the management of the health facilities is being encouraged through the strengthening of the health sub-committees of Community and Village Development Committees. A strong partnership with non-governmental organisations is essential in these works and the MOHS is committed to strengthening its partnership with NGOs and other stakeholders.

3.21 The MOHS in its draft policy does give priority to 'public goods' in the form of preventive care and treatment of communicable diseases such as malaria and tuberculosis that have an impact on others besides the individual directly involved. However, the PETS found that treated mosquito nets were available in only 19% of the health care facilities covered. Some patients interviewed during the review did suggest that quality of care did improve if one established a 'patron-client' relationship with the staff members, without further investigation it can only be assumed that this intimates that it is beneficial to make payments-in-kind to the health workers, a practice that is well acknowledged through anecdotal evidence.

3.22 MOHS policy is to curtail the expansion of tertiary level care in the short-term and to focus on the strengthening of preventive, primary and secondary level care. The MOHS does, however, recognise the need to strengthen some priority areas of tertiary care so as to ensure appropriate referral patterns and a continuum of care, which will be needed to support adequately the secondary and primary levels, and to ensure appropriate opportunities for training of health care workers. The MOHS, having overall responsibility for ensuring adequate public health programmes for priority diseases, is reviewing all its technical policies and guidelines. Revising and updating existing policies and developing new technical policies where needed to guide the provision of services. All health care providers, both public and private, will be expected to conform to the specific technical policies and treatment protocols.

3.23 During the conflict period and especially during the recent past the public health care system has had considerable support from NGOs. For most rural PHUs support from NGOs was vital to maintain the provision of basic services. For health workers this meant supply of basic drugs and medical supplies, basic equipments, payment of

allowances and incentives, supervision, training and capacity building and infrastructure development in many areas. For users the NGO involvement meant greater availability of drugs, motivated staff and no or low user charges and no drug charges in many areas. Since most of the NGOs have now withdrawn from direct health service delivery support and have 'handed back' the services to the MOHS there is a perceived and a real decline in the quality of services in many districts. During the district consultations the user perceptions were recorded and can be summarised in three areas of users' perceived areas of quality: i. Reduced availability of drugs, ii. Higher costs, and iii. Decrease in staff motivation. All health facilities visited during the district consultations reported a reduction in utilisation. This link between perceived quality of service, cost and utilisation needs to be considered by policy makers and health managers, and requires close monitoring by district level management. International experience has shown that generally utilisation will only increase with a cost increase if there is an increase in quality as perceived by the user. Fig 3.2 below gives a simple model on the relationship between cost, quality and utilisation; the recent experience in Sierra Leone is likely to be represented by (c).

Fig 3.2: Cost, Quality and Utilisation in public health care

(a).	Cost/user fees (Increase) ↑	Quality (Increase) ↑	Utilisation (Increase) ↑
(b).	Cost/user fees (Increase) ↑	Quality (Remains the same) →	Utilisation (Decreases) ↓
(c).	Cost/user fees (Increase) ↑	Quality (Decreases) ↓	Utilisation (Large decrease) ↓↓

Community participation in health

3.24 The focus for people's participation in the planning, implementation and monitoring of health care delivery is through the Community Development Committees, and sub committees, e.g. health sub-committee and other community-based organisations, such as the District AIDS Committee, etc. There are enormous potential benefits of enhancing the livelihoods of the rural poor through decentralisation, through effective representation and accountability which can be achieved through a parallel process of community-based activities (led by civil society and other informal structures, such as women's clubs, etc) and complemented by institutional reforms. At district and national levels there are encouraging examples of participation of civil society in the health sector, some District Health Management Teams are expanding to include representation from district based NGOs and private for profit and not for profit providers.

3.25 Gender relations in Sierra Leone also have a great impact on who benefits from current care provision and involvement in its planning. Women have less access to cash, fewer economic opportunities and limited control over household resources and decision-making. Women also provide a disproportionate burden of informal health care provision in households and communities, which is not valued, quantified or taken into account in planning primary health care services so it is vital that they participate in all aspects of the planning and management of health services.

3.26 The PRSP process is therefore an opportunity to refine and redirect the health sector interventions towards those in the country that poverty is impacting on the most. It is therefore important to ensure that resources are targeted towards improving the quality of services and increased access for those that need it most and that this is monitored through gender and poverty sensitive targets and indicators.

3.27 Addressing poverty in the health sector should not focus solely on supply-side issues of health care provision. Poor people, and vulnerable populations, have the capability and right to participate in their own development. The PRSP provides an opportunity to promote the demand side of health care, through wide stakeholder involvement and a rights-based approach, however there is huge need for a greater understanding by the formal health sector of the roles of cultural and traditional norms relating to health seeking behaviour in Sierra Leone. The first step in this process is to understand the views of the poor on the services available to them, and their constraints accessing health care. This should not only be a once-off exercise during the development of the PRSP, but be an ongoing process for planning, monitoring and evaluation of the health sector as a whole.

3.28 A second step to fostering the demand-side of health is to promote the accountability and responsiveness of the health sector to its' users (and non-users), particularly the poor. At the moment, accountability in the (public) health sector is seen primarily in a hierarchical way with people reporting to their superiors at each level. The links to the service users (or non-users) and wider civil society are at an early stage. The current decentralisation of government and devolution of power to District Councils provides an opportunity to promote good governance in the health sector through the strengthening of democratic structures within the district, from the Community Development Committees to the District Council. The PRSP implementation can support this process through increased public accountability at different levels of the health sector.

3.29 Non-governmental and civil society organisations (NGOs, CSOs) have a role to play in promoting accountability and responsiveness of the health sector. It is important to note the diversity of the NGOs and CSOs in relation to different aspects of health, e.g. health providers, provision of support to health providers, strengthening of health care providers, health-focussed community-based organisations, user groups, and wider rights-based organisations and networks, particularly women's organisations. The role of health NGOs in providing essential health services in partnership with GOSL is further discussed in Chapter 5. In the current situation of emerging democratic structures, NGOs and CSOs provide a complementary mechanism to have user views represented in the planning and monitoring of health services.

3.30 Poverty alleviation through improved health outcomes does not depend solely on health service provision. Major pro-poor health gains will be achieved through inter-sectoral linkages. The PRSP implementation is an opportunity to ensure a framework to promote health across all sectors so a comprehensive effort to implement all five pillars of the PRSP is the best opportunity for some real gains for the poor of Sierra Leone.

Conclusion

3.31 For equity to be accepted as a fundamental policy goal there has to be a general understanding and acceptance by the community of the reasons for inequality in health. Policy statements acknowledging this must be translated into strategies with real targets to address the issue and need to be closely monitored to ensure that they are really changing both the allocation of resources and improving the access of those that most need them.

3.32 Recommendations

- The MOHS must ensure that all its strategies have targets that address the equitable distribution of resources to meet those most in need in the country.
 - All indicators used to measure progress of strategies need to be monitored on a regular basis and action taken to address findings.
-

4. Gender and Health

4.1 In Sierra Leone females constitute about 51% of the population and most of them live in the rural areas, engaged in subsistence farming, petty trading and management of the family. Over the years the Government has endeavoured to ensure that its programmes address gender issues, tap their potential and move into the mainstream of the country's development

4.2 In 1988 the Women's Bureau was established in the Ministry of Social Welfare. In 1993 a Gender Desk was established in the Office of the Chairman and Head of State, to coordinate gender and development activities in the country. Following the women's conference in Beijing, in 1995, and in recognition of the contribution of women to the development of Sierra Leone, the newly elected government established a Ministry of Gender and Children's Affairs. This signalled a novel and significant commitment by the Government to address gender issues at the highest level, a move that gave encouragement to women.

4.3 The new Ministry brought together stakeholders and galvanized support from Donors, government institutions, NGOs and civil society and developed a Programme of Action for the period 1997 –2001, called "A vision for Women and Children for the Millennium". Laudable as it was, this Programme of Action had the potential to mainstream gender into the development process and empower women for personal as well as national advancement. The Ministry of Gender and Children's Affairs was later merged with that of Social Welfare to form the Ministry of Social Welfare, Gender and Children's Affairs. Since this merger, the Programme of Action has not been implemented.

4.4 Nevertheless, the Ministry commissioned the development of two policies: the one on Gender Mainstreaming, and the other on the Advancement of Women. The Gender Mainstreaming Policy was to form an integral part of the national development process and reinforce the overall development objectives in the country. The Policy emphasized Government's commitment to gender responsive development. It further sought to strengthen and provide a legal basis for gender-oriented sectoral policies.

4.5 The guiding principle underlying the Policy for the Advancement of Women was that Government continues to uphold the principles entrenched in the Constitution of Sierra Leone which guarantees equal rights for women and men. Furthermore, the Government continues to be committed to the provisions of the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which was signed on September 21, 1988. The Government signed the Optional Protocol to CEDAW on September 8, 2000. The Government is also committed to all other International Instruments relating to the advancement of women, to which the Sierra Leone is a signatory, though level of implementation of these declarations, protocols and policies vary.

4.6 Women have the right to enjoy the highest attainable standard of physical and mental health. Their enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. Because women are visible in the health care system both as caregivers and as clients, there is widespread misconception that health projects automatically address women's empowerment. Gender gaps in health status, in access and use of health services, and health outcomes persist, signifying a need to address gender inequality in health sector reforms.

4.7 In many developing countries the availability and quality of health care has been further reduced because of the deterioration of public health systems and the

privatization of health care systems without appropriate guarantees of universal access to affordable health care. This situation not only directly affects the health of girls and women, but also places disproportionate responsibilities on women. Their multiple roles, including their roles within the family and the community, are often not acknowledged; hence, they do not receive the necessary social, psychological, and economic support.

4.8 The UNDP Human Development Index (HDI) is a composite of three indices used to measure human progress: GDP Index (per capita income adjusted), Life Expectancy Index (Access to health, sanitation and clean water facilities), and Education Index. The HDI for 2003 Human Development Report is 0.275 for Sierra Leone where Life Expectancy Index is 0.16 (34.5 years), as compared to 0.66 (64.4 years) for Developing Countries. Poverty is also the absence of some basic capabilities to functions. The Gender Development Index (GDI) focuses on the same three indicators as the HDI. Life Expectancy is one of the capabilities identified by the GDI of the UN Human Development Report, which represents Gender differences in health and well being.

4.9 A major problem, which affects women, is the high maternal mortality in Sierra Leone. According to the MICS 2 Survey report (2000), the maternal mortality rate for Sierra Leone is 1800/100 000 live births. It is estimated that Sierra Leone has about the highest maternal mortality rate in Sub-Saharan Africa. In fact the estimated Maternal Mortality rate for Sierra Leone is about three times higher than the average maternal mortality rate for the sub-region (See table 2.2)

4.10 The major direct medical causes of poor maternal health outcomes, accounting for about 80% of all maternal deaths, are now well known. As a result of the increased understanding of the medical causes of maternal death, attention over the years has focused on developing strategies to reduce the high levels of maternal mortality that occur in many developing countries. Some of the short-term interventions include those, which take place before, during, and after pregnancy and birth. These interventions include improving women's access to family planning services, services for the prevention and management of STIs, and improving the quality of maternity care. Despite these efforts, pregnancy and childbirth continue to be life-threatening events for many women.

4.11 Clearly, maternal mortality is more than just a medical problem. Maternal mortality is evidently the result of the interaction of a variety of factors, which serve to limit women's access to maternal health care services. These factors have social, cultural, religious, educational, economic bases. The health status of the women is also a contributing factor.

The powerlessness of women increases their vulnerability.

4.12 Here in Sierra Leone the educational level is lower for women than for men; women depend on their husbands or male partners to make decisions affecting their health, because usually it is the men that have the economic power in the home. Many women do not earn any wages and cannot afford the basic necessities of life. In fact, societal norms dictate that women are often not treated as equals of men. Thus the wife and the children are at the mercy of the husband for all decisions. Women have no or little influence over decision making including control over their body. Important decisions taken at the household level include those relating to the practice of family planning, seeking health care in cases of emergency, and timing of marriage. Early marriage is a serious threat to the health of adolescents and teenagers. Yet parents, especially fathers, are not aware of the risks posed by teenage pregnancy. In areas, where early marriage is more frequently practiced, the young girls either do not go to school, or drop out of school for this reason.

4.13 Although no national study on early marriage has yet been conducted in Sierra Leone, ad hoc studies suggest that this is in deed a problem. Results of a study conducted at a tertiary hospital indicated that 73% of teenagers attending antenatal clinic were married. Early marriage and early childbearing continue to curtail educational opportunities for young women in sierra Leone. The illiteracy rate among the under 15 years is reported as 82% for females compared to 55% for males. (State of Women and Children Report, 1995).

4.14 Like early marriage, female circumcision, otherwise referred to as female genital mutilation (FGM) is a deeply rooted traditional practice. It is generally accepted as a form of violence against girls and women that has serious physical and psychological consequences. It has adverse effects on the health of those affected and it is a reflection of discrimination against women and girls. FGM is known to be prevalent in most countries of the WHO African Region. In some countries, the practice is widespread, while in others; it is limited to a few ethnic groups.

4.15 In Sierra Leone, FGM is practiced among virtually all ethnic groups with varying levels of prevalence in those groups. This practice is intimately associated with the "initiation" rituals for girls. Formerly female initiation among most ethnic groups took place within a few years before a girl reached puberty. This was so because during this socialization process the girls learn to be women, housewives and mothers. However, in recent years the age of initiation has reduced significantly and, it is not uncommon to see female infants and toddlers being initiated. In such cases the socialization process is completely absent and the traditional operation, FGM, attains prominence.

4.16 While this practice is widely condemned as a harmful traditional practice and a violation of women's human rights, with immediate and long term health consequences among those affected, there has been no systematic study in Sierra Leone to document the actual prevalence and incidence of its adverse effects or the direct relationship between the observed complications and FGM. It does seem that efforts to abolish this practice will continue to be hampered by the lack of scientific studies which establish a direct correlation between this practice and say, any long term reproductive health complications.

4.17 Another health problem with a gender dimension is that posed by HIV/AIDS. Women of all ages are more likely than men to become infected with HIV during unprotected vaginal intercourse. Compounding their biological vulnerability is the low status of women in society. As a result, they cannot negotiate safe sex. The interplay of biological, cultural and economic factors makes young girls particularly vulnerable to the sexual transmission of HIV.

4.18 The Government of Sierra Leone is now organizing a multisectoral response to the growing epidemic of HIV/AIDS through the Sierra Leone HIV/AIDS Project (SHARP). The project has four components covering: Capacity Building, Policy Coordination and Refugee Activities, Prevention and Care, Health Sector Response to STI/HIV Management and Community and Civil Society Initiatives (CCSI).

4.19 The HIV/AIDS crisis has far-reaching implications for the attainment of the Millennium Development Goals (MDGs). One of the goals is to reduce HIV prevalence in persons aged 15-24 by 25% in the worst affected countries, and by 2010 globally.

4.20 The impact of HIV/AIDS is unique because AIDS kills adults in the prime of their lives, thus depriving families, communities, and entire nations of their young and most productive people. Adding to an already heavy disease burden in poor countries, the

HIV/AIDS epidemic is deepening and spreading poverty, reversing human development, worsening gender inequalities, eroding the capacity of the government to provide essential services, reducing labour productivity.

4.21 As families lose their breadwinners and caretakers, income is lost, agricultural output declines, nutrition worsens, spending on healthcare increases, savings turn into debt, children drop out of school, the health status of individuals deteriorates. The Government approved a National HIV/AIDS Policy. The Policy covers the following areas: Multisectoral Approach and Partnerships, Respect for Human Rights, Monitoring, Evaluation and Research, Universal Access to Information, and Advocacy. There were however gaps within the policy as follows:

- Lack of clear cut guidelines on legal issues relating to discrimination and wilful infection of an individual
- Access to essential basic services for people living with HIV/AIDS not clear
- Issues of Voluntary Counselling and Testing not addressed
- Issues of Orphans and other vulnerable children not addressed

4.22 Consequently, the following changes in the policy are proposed:

- Recognizing the roles of communities and people living with HIV/AIDS in addressing the stigma and denial surrounding the epidemic
- Budgetary allocations to the various Line Ministries for HIV/AIDS should be placed within the Medium Term Expenditure Framework (MTEF)
- Special efforts are needed for women to ensure access to social services, land, credit, employment opportunities and improved agricultural techniques
- There should be programmes that empower people politically, socially and economically to reduce their vulnerability to HIV/AIDS
- Improved access to Antiretroviral Therapy (ART) with full involvement of the Ministry of Finance for adequate funding

4.23 Gender inequality was evident during the decade long rebel war in Sierra Leone. In a study on Children in Difficult Situations in Sierra Leone, the children reported numerous cases of sexual exploitation, including rape. Listening to the children in that study, it was easy to conclude that girls were more disturbingly affected by the war than were the boys. The girls were more the victims than the perpetrators. They had nothing to command. They were not in control of what happened to them. They were the ones that were sexually exploited, abused, and raped. They served as wives to the commanders and other members of the fighting forces. The boys, on the other hand, became commanders of "Small Boys Units" and had other boys under their command. They could do things to satisfy their perceived ego.

4.24 To address some of the problems discussed above, the following broad objectives need to be considered in all future strategies:

- To give priority to the prevention and reduction of maternal mortality
- To provide accessible, affordable and well equipped health care facilities with well trained and motivated staff especially in the rural areas.
- To avert harmful traditional practices
- To promote public education and community mobilization for the empowerment of women
- To prevent and control HIV/AIDS

Addressing gender inequality is a long process and requires a concerted effort by all policy and decision makers to ensure that concrete steps are taken to address it.

4.25 Recommendations

- Conduct a national study on maternal mortality to determine the extent of the problem
- Promotion of effective Reproductive Health services, incorporating male involvement
- Removal of barriers to the utilization of health care services
- Public education for the promotion of elimination of harmful traditional practices
- Policy: Review National HIV/AIDS Policy, formulate Gender Policy and National Reproductive Health Policy
- Collect and present data disaggregated by sex to ensure that gender concerns are addressed

5. Policy and Legislation

5.1 The policy framework for health in Sierra Leone is encompassed in the draft National Health Policy of 2002. At the start of that year the MOHS decided to revise the National Health Policy of 1993 taking into consideration changed context in the country compared to 10 years previously, when that document was prepared.

5.2 In formulating the policy, the MOHS engaged consultants who reviewed all relevant documents, with the 1993 National Health Policy serving as the framework document. This was followed by wide-ranging consultations with stakeholders including donors, NGOs, civil society, MOHS staff at headquarters and in the Districts and staff from other sectors. Priority issues were identified and a two-day workshop was organized to discuss and review the outcome of this consultative process.

National Health Policy 2002 (Draft)

5.3 The final policy document has as the overall objective, a commitment to ensuring good health for all Sierra Leonean citizens, within the country's borders, to be provided in an equitable manner. This will be achieved through;

- Providing good public health services, ensuring food safety and taking effective action against specific communicable diseases;
- MOHS will provide the necessary leadership, advocacy and intersectoral cooperation for health promotion;
- Prioritization, to achieve maximum benefit from resource utilization;
- Good communication with all stakeholders including communities;
- Establishment of a Council for Health Nutrition and Sanitation.
- Health care delivery will be through an integrated network of primary, secondary and tertiary systems with well developed guidelines to ensure quality output at each level;
- Establish dialogue with stakeholders outside the public sector;
- Put in place mechanisms for quality assurance in the non-public sector through registration with professional councils and boards;
- Institute code of practice and training schemes for Traditional Birth Attendants;
- Address the issues of shortages and inadequate human resource in the sector. As a first step a human resource plan will be drawn;
- Explore the possibility of starting a national health insurance scheme;
- Ensuring that national plans include processes, timeframes, output indicators, monitoring and evaluation;
- At the end of each year to have a review of all programs and activities in the sector;
- Publication of an Annual Report on the Health of the Nation.

Technical Policies

5.4 Further support to the National Health Policy was provided by the development of technical policies dealing with malaria, Environmental Health, Health Education, Traditional Medicine National Drugs HIV/AIDS, these built on the technical issues dealt with the Primary Health Care Handbook. These policies fine-tuned the broad goals in the National Health Policy, in their respective areas, emphasizing issues such as equity and burden of disease. One of these, i.e. The National Drug Policy, will be briefly discussed.

The National Drugs Policy

5.5 This is a key policy document for a variety of reasons including the fact the sector policy sets the timely availability of affordable drugs as one of the ways of achieving its stated objectives, and secondly in all beneficiary surveys undertaken by and on behalf of the Ministry of Health, this issue has remained very high in their assessment of a quality health service.

5.6 The document deals with institutional responsibility for pharmaceuticals in the MOHS. It addresses the issues of procurement, storage, distribution and inventory control, as well as providing guidelines for any donations and rational use of drugs. Whilst the drug policy fits in with the general health policy of 2002, there are certain parts that need to be revisited especially with decentralization within the sector, and the advent of local government institutions.

5.7 The relationship between the Pharmacy Department and the private sectors will need to be given further consideration in view of the stated objective of improving public/private partnership for the overall benefit of the consumer.

Policy Analysis

5.8 A health policy consists of a set of goals and targets, based on an assessment of the prevailing health conditions that are desired within an agreed time frame, usually about five years. From this should flow the next steps leading ultimately to the development of process and parameters for monitoring evaluation and review; always keeping in sight the big picture i.e. the goals and targets set out in the policy: see figure 5.1.

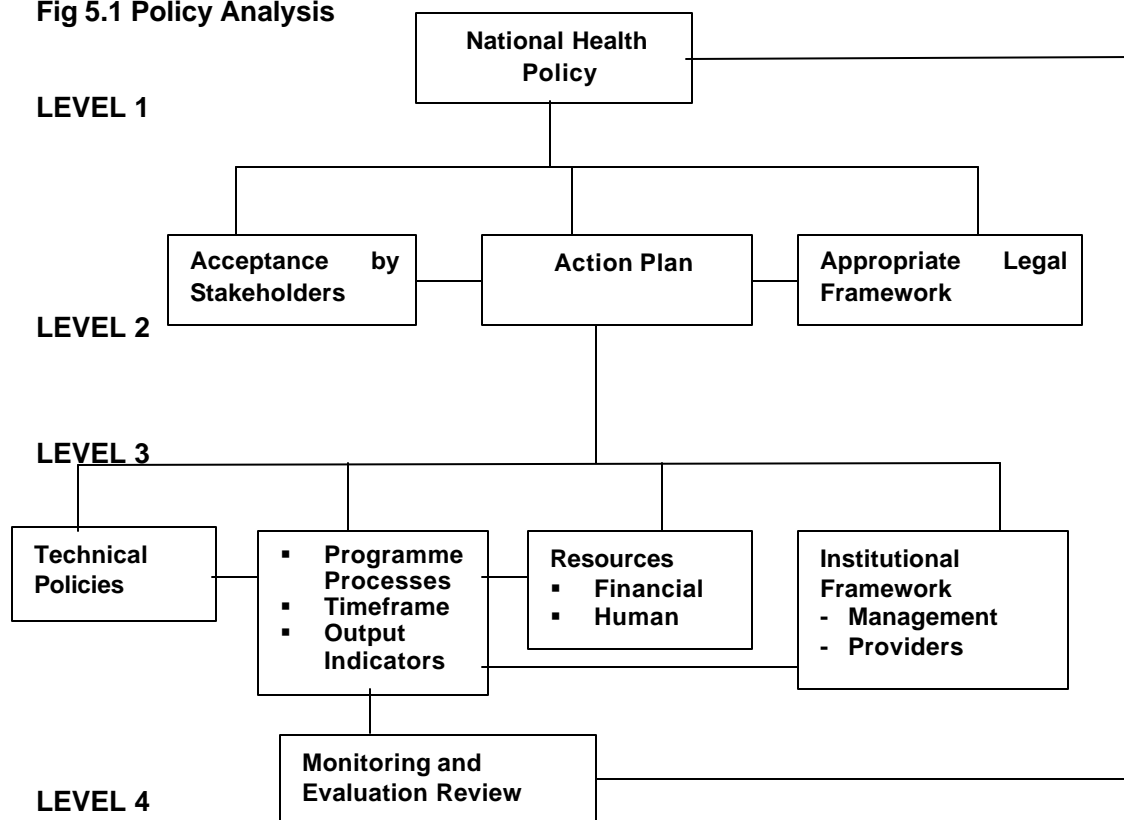
Level 1: The process by which the policy was developed, and the agreed goals and targets contained therein, ensured sectoral ownership and should provide a good challenge for implementation within the agreed time-frame.

Level 2: Acceptance by stakeholders. There seems to be broad stakeholder acceptance. This was ensured by the participatory process used in policy formulation. It is a stakeholder policy rather than a MOHS policy. There do exist, technical policies amplifying certain programs and interventions. There is a final stage through which the document has to go to ensure total government commitment i.e. presentation to the parliamentary process.

Action Plan, There are 3 -Year Rolling Plans which focus on resources and programs required to address broadly the goals and targets set out in the policy.

Appropriate legal framework. There is a huge gap in this area the details of which are considered under "legal framework".

Level 3: Technical Policies Some of these pre-date the present sectoral policy, e.g. the Drug Policy. The changed political context with the establishment of local authorities would necessitate a revisit to at least some of these policies.

Fig 5.1 Policy Analysis

Resources and Institutional Framework and Review

5.9 The current planning focused adequately on these issues. It is a continuously evolving process. There are challenges ahead in trying to put together all loose ends, such as responsibility for resource allocation and disbursement, staffing, responsibility for hiring and firing of the various cadres. Some of these questions will not be answered until the final make-up of various districts structures is established. The MOHS should be an integral part of the discussion that will ensue between the various parties concerned. The annual review provides an opportunity to determine whether the proposed programmes are achieving the policy objectives.

5.10 Recommendation

- A National Health Action Plan should be designed with programs to address the policy objectives within a specific time frame e.g. 5 – 8 years. This will serve as the reference document guiding District planning and the 3 – Year Rolling Plan.
- There is a need to develop technical policies for all priority areas that currently do not have one, and a need to develop a system for revising existing technical policies on an ongoing basis.

Health Legislation

5.11 There are several ordinances relating to health which could broadly be placed within three time frames. Pre 1960, 1960 and Post 1960. Together these constitute the statues regulating the health system in Sierra Leone.

5.12 Pre-1960

Most of these ordinances dealt with staff recruitment and training as well as the establishment of institutions of research and training—viz.

- Cap. 151 - The Medical Practitioners and Dentists Act
- Cap. 152 - The Nurses Act
- Cap. 153 - The Midwives Act
- Cap. 154 - The Dangerous Drugs Act
- Cap. 155 - The Medical Research Act
- Cap. 156 - The West African Institute of Trypanosomiasis Research Act
- Cap. 157 - The Lunacy Act.

Some of these have been superceded by more recent Acts, however Caps. 152, 153, 155 and 157 are still operational.

5.13 1960 – The Public Health Ordinance

This is still the operational legal document for public health in Sierra Leone. In it, the role of the Minister in the appointment of the various functionaries responsible for running the health system was clearly defined, as well as a host of other issues relating to clinical care, public health, environmental sanitation and food safety. To date this document remains the only piece of legislation that addresses most of the health issues in the country. It is out-dated with regards to present day institutions, processes, patterns of disease and political boundaries. In spite of promises by all administrations to date to revisit this ordinance, nothing of substance has so far been done.

5.14 Post-1960

5.14.1 1994 – The Medical Practitioners and Dental Surgeons Act.

This ordinance was enacted to establish the Medical and Dental Council. Supplements were published in 1996 and 2001. It defined the composition and functions of the council including

- registration of all doctors and dentists practising, or about to go into practice in Sierra Leone.
- establishment of a Disciplinary Committee as an arm of council, responsible for dealing with complaints against practitioners.
- drawing up of a code of ethics for doctors and dentists.
- accreditation of training institutions for doctors and dentists.

The Disciplinary Committee under this Act has the power to issue summons and to subpoena documents. Evidence is given under oath and legal assistance could be provided during the enquiry. The punitive powers of the council are however restricted to reprimand, suspension from practice and removal of the person's name from the register. Offences dealt with under the Act include

- falsely presenting oneself as a qualified medical or dental practitioner,
- practising whilst not registered
- providing false registration details
- wilful destruction of a Register

5.14.2 2001 – The Pharmacy and Drugs Act

The Act providing for the establishment of a Pharmacy Board which amongst its functions as responsible registration and discipline of Pharmacists.

It deals with drug maintenance input, export, procurement, donation storage and transpiration. It also spells out punishments to offences committed under the Act.

5.14.3 2003 – The Hospital Boards Act

Through this Act, hospitals listed in schedules I and II of the Act will be managed by Hospital Boards. The composition powers and functions of the board are also spelt out in this document. Boards are expected to take over completely the management of their respective hospital as autonomous corporate bodies responsible for the structures and resources under their mandate.

5.15 The present time presents a unique opportunity for overhauling the legislative framework for health care delivery. Mitigating circumstances at this time include:

- the return of peace to the country after years of civil war.
- the change in focus reflected in the new policy document and the 3-Year Rolling Plan from emergency care to rehabilitation and development
- The ongoing decentralization at the MOHS.
- Political decentralization with the re-establishment of local government.
- The debate has already started about how to seamlessly merge the envisaged roles of different institution such as the new Hospital Boards and the soon to be established local authorities.

5.16 Recommendation

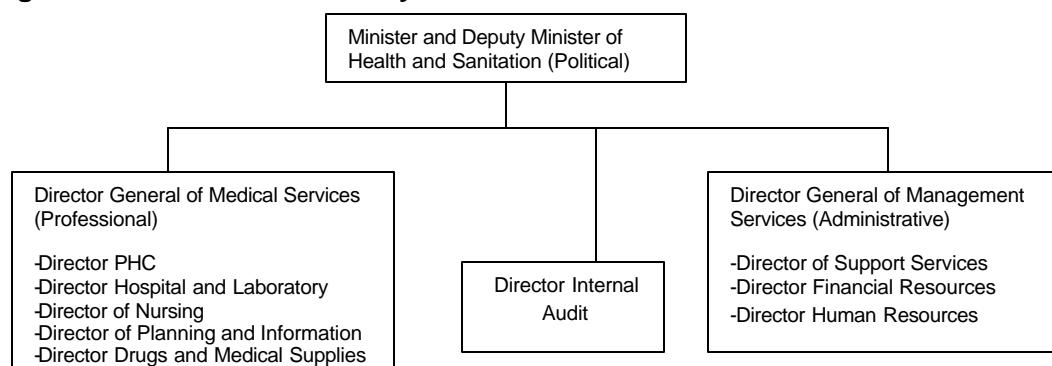
- It is recommended that priority be given to the overhauling of the legal framework for health. An all-inclusive new ordinance should be formulated. In doing so the current legal documents, the National Health Policy and the new local government ordinance should form the working documents.

6. Organisational Structure

6.1 The Ministry of Health and Sanitation bears the principal responsibility for the Health Sector. The main focus of the structure of this sector is thus the MOHS. The overall head of the Ministry is the Minister of Health and Sanitation. Over the years the Minister of this sector has been given additional responsibilities to those for health. This has been reflected in the official nomenclature of the sector at the time. This has varied from simply Ministry of Health, through Ministry of Health, Sports and Youth, Department of Health and Social Services, Department of Health, and Ministry of Health and Sanitation (MOHS). Whatever the nomenclature, the Ministry of Health continues to carry the mandate for the health and well being of the nation.

6.2 There are three broad areas of responsibility in the ministry, namely political, administrative and professional. The Political Head is the Minister, supported by a Deputy Minister. The present organizational structure of the MOHS, see Fig 6.1 below, is a reflection of the restructuring and reorganization of the Ministry that became inevitable in order to implement the 1994 National Health Action Plan. The Professional Head of the Ministry was re-designated Director General of Medical Services, while the Administrative Head became the Director General Management Services. Following the Directors General in hierarchy were the Directors, and the Programme Managers of the various Technical Programmes.

Fig 6.1: Structure of the Ministry of Health and Sanitation



Source: Ministry of Health and Sanitation, March 2002

6.3 Although the new structure does not specifically have designations for Deputy Director General, this was however implied, and practiced. The Director of Primary Health Care and the Director of Hospital and Laboratory Services are respectively the Deputy Directors for Primary Health Care and Clinical Services. Three other directorates exist on the professional side: Director of Planning and Information, Director of Drugs and Medical Supplies, and Director of Nursing. Managers for the various Programmes under each of these Directorates support that Directorate.

6.4 Following the Management and Functional Review of the Ministry of Health and Sanitation by a group of DFID and national consultants a new organizational structure for the MOHS was proposed. It was proposed to divide the responsibilities of the Directorate of PHC between two Deputies: one for Disease prevention and the other for district operations. At the time of this Sector Review, the Ministry of Health and Sanitation had already partially implemented the DFID recommendation: A new Directorate, the Directorate for Disease Prevention and Control (DPC), has been created to take over some of the responsibilities of the Directorate of PHC. The assigned responsibilities for the new Directorate are consistent with those recommended for one of the Deputy positions for PHC in the proposed organizational structure for the MOHS.

While the MOHS has not yet fully adopted the proposed organizational Structure, it is important that in the process of any re-organisation of the current structure of the MOHS the organisational structures to coordinate environmental health needs to be considered, as issues of environmental health are fundamental to the underlying causes of ill-health in Sierra Leone.

6.5 There is now no provision in the structure for the position of Principal Medical Officer (PMO). This was a consequence of recommendations from the National Health Action Plan (1994) since it was found that “the position of PMO is considered untenable, as the disadvantages for perpetuating the position outweigh the advantages of doing so.”

6.6 At District Level, the District Health Management Team (DHMT) oversees all PHC activities delivered through the PHUs. A District Medical Officer (DMO), who is ideally a trained Public Health Physician, heads the DHMT. The District Medical Officer, responsible for the administration and supervision of health care delivery in the district, now reports directly to Headquarters, and not through a PMO. A Medical Officer is responsible for clinical activities at the district hospital. At the provincial or national hospitals, the Medical Superintendent or Hospital Manager is responsible for administration and supervision.

6.7 The health care delivery system is highly centralized. However, the National Health Policy of 1993 provided for the decentralization of the administrative structures of the health services and the creation of Health Boards at district level. Although this situation has not yet been achieved, MOHS has established Hospital management committees in certain hospitals to strengthen the management of the delivery of health services in these hospitals.

6.8 As part of the Decentralization process to devolve authority to Local Governments, Government enacted “The Hospital Boards Act, 2003”, “ to establish Hospital Boards for the better management of specific hospitals and the provision of efficient medical care in the Western Area and all districts of Sierra Leone and to provide for other related matters.”

6.9 As of January 2004, each district, including the Western Area, now has a Hospital Board, as prescribed for in the Act. These Boards are now actively working towards establishing their modus operandi in their respective communities within the context of decentralization. There seems, however, to be confusion with regards to the roles and responsibilities of these Boards vis-à-vis those of the central Ministry. During the extensive consultations held in the districts as part of this review, it became clear that the Hospital Boards seemed to be regarded as District Health Boards, in spite of their nomenclature.

6.10 Recommendations

- Need for the MOHS to adapt and adopt the new Organizational Structure proposed by the recently concluded Management and Functional Review of the Ministry
- Need to ensure that the MOHS role in environmental health, and in particular sanitation, is reflected in the MOHS’s organisational structure
- Need to clarify the organisational linkages between the newly formed Hospital Boards and the central MOHS

7. Health Financing

How the health sector is currently financed in Sierra Leone.

7.1 Health in Sierra Leone is financed in a number of ways. Public health services are largely funded by the Government of Sierra Leone (GOSL) through revenue raising and with support from development partners, either grants or loans, there are also charges for services and drugs so revenue is raised through different cost-recovery mechanisms within the services. The main government provider of health in the country is the Ministry of Health and Sanitation (MOHS), the military and police forces also provide some care which is financed by GOSL. The second main group of health providers are the churches and NGOs. The GOSL does pay some subvention to the church health institutions from time to time but they are mainly self-financing through user fees, donations and donor assistance. There is a small private-for-profit sector in Sierra Leone, which is mostly limited to the Western Area and the other larger urban areas. There is still a considerably large traditional health sector in Sierra Leone, of which little is known in terms of size and financing.

7.2 In the last public expenditure review done on health it was found that for the three-year period 1999-2001 government expenditure on health increased from 4.8 to 7.1% and expenditure as a percentage of GDP rose from 0.7 to 1.4%. Nevertheless, given the current level of government expenditure against budget, 82% for health in 2003, it still represents just over US\$2 per head of population for 2004. As Sierra Leone is dependent on the import of pharmaceuticals, medical supplies and other health care inputs, the current level of expenditure is not adequate to keep the health system functioning at an effective level. Government expenditure on health is of particular importance as the public health services in Sierra Leone are the major source of health care for the large proportion of people living below the poverty line, and in rural areas, who are not serviced by the private sector.

7.3 Results from the Sierra Leone Integrated Household Living Conditions Survey (SLIHLCS, 2004) shows that average national household expenditure per capita on health is Le95,708 (approx. US\$38), see table 7.1 the MOHS budget for 2004 is approximately Le.36 billion, approximately Le7,168 (approx. US\$2.87) per capita.

7.4 There is a tendency among policy makers and planners to view this household expenditure as a source of health sector funding if it could be redirected into funding the public health sector through user fees. In reviewing the household expenditure on health it is important to note how the average is being pulled upwards by the wealthier Western Area and more urbanised districts. It is also important to note that there is need to have intra differentials on household expenditure for these districts as this averaging of figures can hide the poor households. Vital to the interpretation of the data is an understanding and consideration of the absolute level of expenditure and consumption in the households, and the need for a deeper understanding of the impact of such expenditure. Equating actual household expenditure with ability to pay in the context of a poor nation such as Sierra Leone is inappropriate. While people may pay it does not mean that they really have the ability to pay and payments for health may be made at an opportunity cost of not doing something else.

7.5 It is MOHS policy to charge for services. There are currently a number of schemes operating, namely user fees and cost-recovery. These were initiated initially as a result of the Bamako Initiative. The draft National Health Policy states that the MOHS will review such schemes so as to develop a unified charging system consistent with its principles of equity. This will include mechanisms for exemptions for vulnerable groups and for those conditions which on public health grounds, warrant exemption. The GOSL

policies, in pursuance of poverty alleviation, is to exempt school-going children, under-fives, pregnant women, lactating mothers up to 12 months duration and citizens over 65 years of age, however these exemptions are derived from political speeches and are not set out in any MOHS directive to health service providers.

Table 7.1: Average per Capita Household Expenditure on Health

Districts	District Population. (a)	No. of functioning PHUs 2003	HH Expenditure on Health Le.	Mean HH Size	Average per Capita Expenditure on Health Le.
Bombali	390,000	63	384,232	6.57	58,482
Tonkolili	395,000	68	227,281	6.04	37,629
Kailahun	294,000	28	142,605	6.00	23,767
Koinadugu	232,500	31	362,838	6.51	55,735
Bonthe	183,000	24	623,615	6.56	95,063
Kenema	490,500	79	294,093	5.27	55,805
Kambia	231,500	30	320,727	7.04	45,558
Port Loko	509,500	68	395,952	6.72	58,921
Kono	353,500	57	786,728	6.22	126,484
Bo	552,500	24	1,259,609	6.23	202,184
Moyamba	372,000	56	621,524	6.11	101,722
Pujehun	229,000	40	243,150	5.09	47,770
Western	812,000	33	1,056,125	6.78	155,770
Total	5,045,000	655	589,564	6.16	95,708

(a) Population is based on Statistics Sierra Leone projections for Census 2004.

Source: Sierra Leone Integrated Household Living Conditions Survey, 2004

7.6 The Public Expenditure Review (PER) on health in 2002 found that although most of the revenue from fees is kept locally (90%), the reported collection of fees amounted to only about 2% of operating expenditures for the MOHS in 2001. Similarly, charges for drugs represented only 2% of the total purchased drugs. No fee collection was reported for more than half of the districts and only a few facilities participated in the drug scheme, though all were covered by the new drug cost-recovery scheme during this review.

7.8 The MOHS does not issue guidelines on the setting of user fees but rather mandates the different providers of care to set their own charges for fee-for-service. The MOHS through its Central Medical Stores (CMS) does issue a list of prices for drugs that are to be charged for drugs dispensed; these charges are called 'cost-recovery'. Cost-recovery rates for drugs have reached 60% in the past, exact figures for current performance are not available. The MOHS does encourage that fees are set through the involvement of local stakeholders and users as much as possible. The user fees are set at different rates for the different levels of care. The setting of user fees varies. In some communities they have been set by the local community or village development committee, and some fees set by the local paramount chiefs, some PHUs have had the input of NGOs on the setting of fees. At the district level hospitals have set their fees higher, both to reflect the higher level of care and to reduce inappropriate use of the service. District hospital fees are set in some cases by the hospital management and advisory committees, and in some instances with the input of NGOs. Church and NGO health providers set their own fees without any guidelines from the MOHS or local community.

7.9 Advantages of user fees in the Sierra Leone context:

- There is a willingness and ability to pay for a wide range of health care, including traditional care, public health care services can take advantage of these funds
- Payments encourage more rational use of the service and increases quality of the health care provider – client relationship.
- Different level of fees in line with level of care promotes more rational use of the service and more efficient use of scarce resources all round
- Contributes to revenue generation, especially to meet expenditure on local minor expenditures
- Can be used to promote the introduction of health insurance in the future through patients getting used to the practice of paying for services

7.10 Disadvantages of user fees in the Sierra Leone context:

- Creating greater inequity by discouraging use of the services by poor people, reflected in lower utilisation levels and barriers to seeking care, prolonged delays in raising funds, e.g. extreme cases reported in relation to maternal deaths.
- The potential revenue raising levels are not clear, nor is the actual use the revenue being put to monitored, e.g. staff incentives when the staff are not absorbed into the public service, so they are working as a 'volunteers' and user-fees are being used to subsidise salaries that should be paid by government.
- Fees are being set without proper consideration of whether the fees levels are affordable for all, and if not, is there an effective exemption mechanism in place.
- Without strict adherence to clinical protocols there may be an over use or inappropriate use of medical and diagnostic interventions, because of provider incentives gained from charging fees, this is most likely to happen in secondary and tertiary levels of care.
- DHMTs have limited capacity in financial management to effectively monitor the collection and use of user fees.

Table 7.2: Health sector support to Sierra Leone by development partner

Development Partner	Purpose	Amount of support
World Bank	Health Sector Reconstruction and Development Project, 2003-2005	US\$20 million
	HIV/AIDS support 2003-2006	US\$2.8 million
European Union	Health Sector Support Programme 2002-2006	€28 million
African Development Bank	Strengthening Drug Supply 2002-2005	US\$3.8 million
UNICEF	MCH, Nutrition and EPI support 2004-2006	US\$3 million

7.11 Development partner funding accounts for approximately 50% of the annual health budget at present. Table 7.2 gives a breakdown of the main support by partner and purpose. A number of UN agencies also give support to the MOHS in thematic areas, such as UNFPA in reproductive health, WHO in malaria, HIV/AIDS and policy, WFP in nutrition, the value of their input has not been included in below. In addition there is considerable support provided by NGOs and other donor agencies directly to districts. The MOHS has a Donor/NGO Liaison Officer, and systems are in place to collect as much data as possible on this support to the sector. Currently, all **known** NGOs and Donor support to districts is being reflected in the three-year strategic rolling plan of the MOHS. However, there is still a lot of work to be done in relation to tracking total NGO funding as currently the tracking mechanism gives only NGO inputs to districts and does

not offer an opportunity to review NGO logistical and administrative budgets so that the true cost and value of activities supported is known. There are also a large number of NGOs who report to work in community development and as a result may engage in health related activities such as clean water supply and sanitation; however these NGOs do not liaise with MOHS as they do not see health as their primary purpose.

7.12 Currently the MOHS follows a policy of allocating the greater proportion of its budget to the delivery of primary and secondary health care, 64.4% of total budget. Programme areas can be equated to level of care except for the Primary Health Care programme which is budgeted for at central level but is actually implemented in the districts. The policy also states that the resource allocation system will ensure that allocations of central funding to individual districts and hospitals are consistent with equity and allocative efficiency and take account of differential unit costs between districts.

7.13 There is no weighted formula for allocating programme funding across districts. There are wide variations in the per capita budget on health by district in the country, ranging from Le.2,666.38 in Moyamba to Le.9,135.22 in Western Area, see Table 3.2 above.

7.14 The National Health Policy, 2002, recognises that the current levels of financing of the sector is inadequate even for provision of basic services and sets a policy goal to work to make finances available that are commensurate with other countries in a similar economic condition. The WHO Commission on Macroeconomics and Health (WHO 2001) indicated that spending on health in low income countries such as Sierra Leone needs to increase from current levels to about \$35-45 per capita by 2015 to achieve substantial impact on the major causes of disease. The report argues that investment in health is a necessary precondition for economic development, and that the contribution of a healthy population to a stable and productive economy has in the past been seriously undervalued. With such a target to reach Sierra Leone has a great task ahead in mobilising funds.

Table 7.3 : Funding gap by major programme area, 2004-2006

Programme Area	Est. Cost (US\$ Millions)	GoSL (US\$ Millions)	Development partners (US\$ Millions)	Gap (US\$ Millions)
Policy and administration	7.1 (5%)	2.3	3.4	1.4(3%)
Human resources management and development	7.7 (5%)	3.1	2.1	2.6 (6%)
PHC programmes	28.1 (18%)	8.7	10.6	8.7 (19%)
District PHC services	54.6 (35%)	12	28.5	14 (31%)
Secondary health care	26.4 (17%)	16.3	0.7	9.3 (20%)
Tertiary health care	18.2 (12%)	8.3	4.6	5.1 (11%)
Support services	12.8 (8%)	4	4.4	4.3 (10%)
TOTAL	155 (100%)	55 (35.5%)	54.3 (35.0%)	45.6 (29.5%) (100%)

Source: MOHS Three Year Rolling plan 2004-2006

7.15 Substantial work was undertaken since 2002 to define and cost the current programmes of the MOHS. These are presented in the three-year rolling plan, current plan for 2004-2006. The major sources of funding for the sector in the foreseeable future will remain public, whether through domestic revenues or through external assistance to Sierra Leone, table 7.3 above shows funds by source and the funding gap.

Steps towards increasing financing: Need for policy

7.16 A lot of work has been done over the last number of years to capture all the sources of finance to the health sector, to know their absolute amount and to what purpose they are being put. The MOHS has also done a lot of work on the re-introducing of user fees and cost recovery into a health care system that had grown used to universal free services during the conflict period. However, all this work has been done in the absence of an overarching policy on the financing of the health sector, resulting in a rather fragmented approach to the role that different funding mechanisms are playing in relation to their net contribution to the sector. This is particularly evident in the role of user fees, as discussed above and is compounded by the lack of clear stated policy on how exemptions are to be funded.

7.17 A health financing policy can be used to clarify the respective roles and responsibilities of central and local government in relation to financing of the sector. Again, issues of both resource mobilisation and allocation are pertinent here. Under devolution, the line ministry retains responsibility for policy and standard-setting; and, it is understood that sectoral policy in relation to funding would take precedence over existing legislation within the Local Government Act of 2004 which refers to District Assemblies' ability to levy fees for services at their facilities.

7.18 Among other things, the proposed policy would expound the overarching principles for health financing in the Sierra Leone context (e.g. equity, sustainability) and include a framework for such issues as:

- Negotiating the share of total government expenditure to be allocated to the health sector.
- Negotiating the distribution of total funding between levels of the health system: some inputs are currently budgeted at central level and are subsequently allocated to districts and hospitals;
- Clearly defining the services for which charges may be levied, both within the districts and at hospital level and clearly define those services which will not be charges for.
- Determining the expected roles of different financing and exemption mechanisms over time, and by type of provider.

7.19 The general objectives of a health financing policy are:

- To ensure effectiveness, efficiency and equity in the allocation and utilization of resources in the health sector consistent with the over all objectives of the national health policy, poverty reduction strategy or national recovery plan
- To attain significant additional resources for the health sector and focus their use on cost-effective priority health interventions.
- To ensure full accountability and transparency in the use of these resources

7.20 Steps that would need to be taken to ensure that policy objectives would be attained in Sierra Leone are:

- Increase progressively the level of GOSL financing to the health sector, explore possibility of health levies and other forms of health specific taxation

- Focus the use of public resources on health services that are demonstrably cost-effective, have the greatest impact on reducing mortality and morbidity, and/or have a clear bias to protecting the poor and most vulnerable population as well as taking due consideration of the gender related health care needs and concerns.
- Ensure that recurrent budgets are kept in line with capital budgets
- Strengthen and support the current financing schemes such as user-fees, and investigate health insurance and other community resource mobilisation efforts.
- Promote the growth of private and public-private initiatives.
- Ensure that all financial transactions using government funds should be administered through the financial regulations of the government.

Issues to be address by policy

7.21 The review of public expenditure for health for the period 1999-2001 highlighted a number of issues that still require addressing. In order to take full advantage of capital investments being made in constructing and rehabilitating facilities there is a need to fund related operating expenditures. Currently, the level of recurrent expenditures is too low to provide access to care by the poor and those in rural areas. There is a problem of lack of skilled staff in the PHUs in the rural areas. Although MOHS gives priority to primary health care in its allocation of funds, it will be important to keep a balance in allocations also to primary and secondary care within districts. There are considerable differences in the distribution of resources per head of population between districts, as discussed above. This all contributes to the low utilisation in rural areas. Growth in both recurrent and capital expenditures has been accompanied by increasing dependency on external funding. This can be understood after the conflict and at a time of high capital investment but it does raise questions of sustainability that need to be addressed.

7.22 The need to increase recurrent budget expenses funded from internal sources leads to the issue of additional revenues either through general taxation or fees for services rendered. This needs to be considered in the macroeconomic context of the current low rates of taxation in relation to GDP (14% in 2001), so there may be possible growth expected there. There needs to be more efficient use of existing funds towards more “public goods” which address diseases that have the highest burden on the most vulnerable. Another area is the current household expenditure on health, if through reforms the existing services were more efficient in terms of quality and price then overall utilisation could increase and revenues also, but in this regard any increases in the Sierra Leone context can only be expected to be marginal.

7.23 There is need to undertake work to better identify the poorer people who should be exempt from payment. The same applies to those services that because of their “public good” nature should be either supplied free or subsidized. This will demand additional policy development work, agreement and related regulatory drafting and administration. It should also require enhanced financial management to make possible greater accountability and evaluation. This capacity should be available at facility, district and central levels, and would be concerned not only with accounting for revenue raised but also for its specific use. Any increases in revenue from fees should not exclude the raising of taxation for the purpose of improving the funding of operating expenses for more adequate health services coverage for the poor. All exemption and pricing policies must be clearly stated and disseminated. People are discouraged from seeking care if they are only aware of fees levels and can't raise the funds to pay them and are unaware of the availability of exemptions and the criteria to be exempted. Experience from around the world shows that it is not easy to design needs-based subsidy systems that are both transparent and effective in reaching the poor. It is a difficult challenge to

expand access for the poor while improving service quality and at the same time increasing cost recovery and sustainability.

7.24 The purpose of user fees is something that needs serious policy debate in Sierra Leone. Given the low utilisation rates of PHUs and hospitals it is hardly necessary to use fees to encourage more rational use of services. If the purpose of fees is to raise revenue then there needs to be some close monitoring of what real purpose the use of these fees are being put to. The official MOHS guideline on the use of locally generated revenues still comes from the instructions issued as part of the introduction of the Bamako Initiative in Sierra Leone Operational Guidelines, May 1997⁴, which sets out the use of revenues by level of care. From the interviews conducted as part of this review it was reported that the fees being collected are in the most cases being used to fund staff income, medical and other supplies, patients transport, replace cost of drugs exempted, etc. These are all cost items that are supposed to be met through other sources within the health system. During this review districts visited reported that almost half of their MCHAs were not absorbed into the public service, so they do not receive a salary only a continuation of their training stipend which they received as trainees (see also Chapter 9). While this prevails it will be difficult to ensure any exemption mechanism as any exemption is revenue lost and an income earning opportunity foregone for the PHU staff. Until there are clear mechanisms to replace the funding lost through exemptions it will be difficult to operate an effective exemption system.

7.25 Policy issues to be considered specifically in user fees are as follows:

- Need to be clear on objectives of the user fees: to raise revenue, if so to what extent, or to promote more efficient use of the services, cut down on over and inappropriate use of services.
- Need clear understanding with communities on how they will see the improvement in the services as a result of their payments, how will it be measured?
- Need good information on community income levels, cash availability, seasonal variations on incomes and expenditures.
- Need to ensure that people are not discriminated because of their health care provider, e.g. only church hospital available with higher user fees, Government need to ensure equity by ensuring mechanisms to allocate health resources equitably throughout the country, including by provider.
- Careful consideration needs to be taken on identifying those that will not use the services because of user fees, and why not?
- Need to consider the management skills needed to effectively manage the collection and use of user fees and ensure resources for capacity building are provided.
- Need to set clear targets on revenue generation and determine if the opportunity costs justify.
- Need to consider if there will be organisational changes to complement the use of user-fees, e.g. greater devolvement from the district to PHU level on budget setting and resource use.
- Need systems to monitor the impact on utilisation, and the use of revenues generated.

7.26 Health insurance is another way of raising revenue for the health sector. In the national health policy, 2002 (draft), it states that the MOHS will investigate the possibility

⁴ The operational guidelines states that the use of funds at PHU level is for transport to the district medical stores, cleaning and minor repairs of the PHU, payment for destitutes, community initiated health related activities, emergencies (not specified) and monitoring fees for VDC members.

of health insurance in Sierra Leone. Health insurance schemes usually take two forms: either social/compulsory insurance or some form of private insurance. The introduction of any form of health insurance needs considerable understanding and analysis of the health sector as a market and this could be examined as part of the process to develop a national health financing policy in Sierra Leone.

7.27 Regardless of what health financing strategies are adopted they all have some core issues that they need to consider:

- Resource constraints are government-wide and can be exacerbated by allocation decisions. These cannot be addressed by the MOHS on its own. National support for the health sector is a requirement for effective health financing policy development and implementation.
- Resources are allocated inappropriately at present, favouring the Western Area and high population districts like Bo. Unless the allocation pattern is addressed any additional funding will only contribute to the inequity which will undermine the central policy objective of the MOHS.
- Overall resource allocation to the health sector and within the health sector is poor, lack of sufficient running costs leads to under use of infrastructure and equipment and inability of health workers to do their job the way they are trained.
- The role of NGOs and Churches in the financing of health care needs to be considered for current and future implications. A clear example is the issue of payment of incentives during the emergency period, once over the NGOs stopped payment, meanwhile staff were not absorbed into public service and real income of staff has drastically decreased and with it motivation. The role of partners needs to be considered in all health financing strategies, with the MOHS taking on its regulation and policy role more strongly.
- There needs to be a balance kept between the expenditure on the different inputs to the sector, capital with recurrent, staff training with recurrent, etc. An imbalance in expenditure on one input may lead to under utilisation or inappropriate use of another.
- Management and particularly financial management skills are weak in the sector and organisational change around the planning, budgeting and control of funding needs to be accompanied with the appropriate capacity building of management and other staffs.
- All financing strategies must be assessed and continuously monitored in relation to both equity and efficiency.

Resource allocation

7.28 As already discussed above there are issues to be considered in the allocation of both current funding and any additional funding. The share of the budget or resource envelope allocated to different levels of the health system is but one indicator of potential efficiency, with broad recognition that the provision of quality health services at district level and below is the most cost-effective means of addressing the majority of the health problems faced. In the future poverty-focused expenditure will need to ensure focused sectoral activities as well as overall activities. This can be looked at from the view of allocative and technical efficiency of the resources being used.

Allocative Efficiency

- Geographical: the use of systematic allocation formulae must be committed to and strengthened. They should be expanded to capture non-recurrent resources, such as government development, donor and NGO expenditure

- Level of service Reallocation needs to occur from government expenditure at district hospital level to health centre/community level. There is little room to squeeze tertiary sectors to achieve this. However, further donor funding might feasibly be re-programmed towards the primary level.
- Inter-sectoral: health must receive its share of the government monies formally earmarked for public expenditure. Public expenditure budgets must be monitored in their entirety so as to ensure a share for health.

Technical Efficiency

- Inputs: all health inputs are complementary and unilateral increases in one input must be avoided. Increased capital expenditure will require complementary recurrent funding not only in maintenance and repairs but in human resources, drugs, etc if this capital is to be gainfully employed through the provision of utilised services.
- Vertical disease programme: although already integrated in many ways at the district and national level it will be important to capture all the costs of further integration so as to ensure the efficiency of the interventions.
- Financing reforms are needed: both in terms of equity and efficiency, role of user fees and cost recovery in terms of revenue generation and actual impact on utilisation of services. Greater efficiency in distribution of resources through use of contracting of NGOs and church providers to deliver on behalf of GOSL and removing any duplication of supply.

7.29 As already reported there is no weighted formula for the allocation of funds, Fig 7.1 provides a matrix of the factors that would determine required funding in Sierra Leone and describes the factor and possible data sources. The actual weighting is not done and should be the subject of informed debate among stakeholders.

Fig 7.1: Matrix of factors to determine resource allocation for district health

Weighting factor	Weight	Description/data source
Poverty	To be determined	The current Integrated Household Living Conditions Survey when finalised will produce poverty headcounts throughout the country
Population	To be determined	Statistics Sierra Leone is currently preparing a national population census. This will provide up to date data on populations and revise population growth projections
Health facility infrastructure	To be determined	To reflect supply of services as a proxy for utilisation; measured using number and type of facilities (e.g. CHC, MCHP, etc).
Historical allocation	To be determined	To limit change in any one year, and to manage any potential "shocks" arising from the introduction of systematic allocation. This is something that could be phased out as the other factors take more dominance.
Geographical	To be determined	Districts geographical factors, rivers, coastal terrain, need for boats, 4x4 vehicles, etc. Distance to source of fuel, bank, wholesalers, etc.
District Specific	To be determined	Particular disease patterns in the district that might require additional funds, epidemic prone districts.

7.30 Administration and service delivery costs are driven by different factors and may benefit from separation in any formula. Inclusion of salary and earmarked funding into the resource allocation process is a critical element of a more equitable allocation

process. Spending through these channels is currently determined by staff and possible donor funded projects.

7.31 One key issue is the implication of the devolution process for resource allocation for health. At present, the expectation is that, in the short-term at least, the allocation to the health sector (district level and below) will be protected through sectoral policy, this was proposed previously in Sierra Leone.

Estimating Future Resource Needs

7.32 This review was asked to look at the issue of estimating 'unit cost of services'. The estimation of unit cost of services needs to be addressed from different perspectives, namely; what type of service, to be delivered by whom and at what level, e.g. primary, secondary, etc. This basically means what are the different types of services that will be provided, what cadre of staff will provide them and where will they be provided, e.g. MCHP, CHP, CHC, district hospital, etc. There are a large number of reform processes ongoing at the moment that will impact on the future unit cost of services and therefore need to be considered. These are identified in the following chart and need to be scheduled if any meaningful estimate of unit cost is to be made. What needs to be understood is that to estimate the unit cost of services it is as important that the policy, strategic framework and guidelines are clear and understood as the identification of the actual inputs to be costed, as it is the policy and strategies that will dictate what the inputs will be at the different levels of care.

7.33 Current processes to be considered

- **Human Resources:** A human resource policy is to be developed. The MOHS is currently introducing a new cadre of Community Health Assistant, as well as revising several curriculum. A policy decision must be made on what services the health cadres will be able to deliver in the future and a human resource training and development plan needs to specify a target for their allocation to health facilities.
- **Health Infrastructure:** A large number of facilities are being rehabilitated and constructed. How infrastructure is to be maintained in the future also needs to be considered. There is need for the MOHS to redesignate facilities according to the services that will be provided, this should be linked with the human resource plan, as it is health workers and not buildings that deliver services.
- **Technical Policies:** There are currently a large number of technical policies to guide the health workers interventions, including standard treatment guidelines. However in a number of areas these need to be revised and need to be adopted for use by the different health cadres and by level of care. Linked to this will be the revision of the essential drug list, including medical supplies and specifications for equipment. It is vital that the revision of treatment guidelines is linked with the training plan. There should also be a review of the diagnostic support services, laboratory, x-ray etc and plans made for their factoring in to the estimations to be considered.
- **Other issues to be considered** may include; targets on utilisation and population growth, policy on transportation and its use, future role of contracting out delivery of services, public/private mix initiatives, etc.

7.34 When the framework of strategies and guidelines that decide what services will be provided, where they will be provided and whom they will be provided by are in place then it will be possible to make some reasonable estimate of the unit cost of services, by level of care. It is the role of the senior management in the MOHS to coordinate all the processes identified above, but linking their development towards determining the future

cost of delivering services could be the role of a taskforce which could be specially formed for the purpose.

7.35 Recommendations

- **Policy**, there is need to develop a comprehensive health care financing policy.
- **Resource Mobilisation and allocation**, there is a need to increase overall resources to the sector and a need to ensure greater allocative and technical efficiency in resource allocation, by developing allocation formula.
- The MOHS should establish a taskforce to work on estimating the future unit cost of services.

8. The PRSP, MTEF and Health Sector Financial Management

8.1 Sierra Leone is currently one of the poorest countries in the world, with per capita income estimated at US\$146 in 2001 (UNDP, 2001), and generally a low level of economic and human development. The Government of Sierra Leone is preparing its first full Poverty Reduction Strategy Paper (PRSP), to provide a framework for the allocation of government and donor resources towards activities that are targeted towards poverty reduction which will form the basis for decentralised sectoral programmes, such as health, and will be fully integrated into the Medium-Term Expenditure Framework (MTEF).

Fig 8.1: Proposed Structure of the Sierra Leone PRSP

Pillar 1: To promote Good Governance, Peace and Stability	Ensuring that public and civil society institutions and systems protect and benefit the poor, through strengthened security and stability; legal reforms, civil service reforms, decentralisation, anti-corruption and peace building
Pillar 2: To promote Macroeconomic Stability and Pro-Poor Sustainable Growth	Economically empowering the poor by ensuring macroeconomic stability and reform, development of commercial infrastructure, sustainable industrial development, increased access to services and social protection for the most vulnerable
Pillar 3: To promote Sustainable Rural Livelihood and Community Empowerment	Ensuring the poor have the resources and power to lift themselves out of poverty through greater access to social and community infrastructure, increased household resilience to stresses and shocks, improved natural capital, strengthened social, economic and physical capital
Pillar 4: To promote a Child First and Youth and Gender Sensitive Development	Ensuring that gender, poverty and age disadvantaged people have access to enhanced child welfare, equal opportunities, empowerment and personal capacity building
Pillar 5: To promote a Caring Society that values its people and its Environment	Ensuring that all people are treated as equal in need, especially those unable to benefit from the other pillars; the disabled, the aged, people chronically ill, etc and that all development is done so as to protect the environment for the people of tomorrow.

Source: Poverty Alleviation Strategy Co-ordination Officer (PASCO)

8.2 The future phasing of the implementation of the PRSP will be proposed in a strategy document that will largely entail that programmed activities for poverty reduction will need to be done within the overall framework of the MTEF, whereby future disbursements from HIPC, debt-relief funds, allocations from the GOSL regular budget or other donor/NGO financial support will be factored. Action undertaken outside of the health sector can have health effects much greater than those obtained within it, therefore the multi-sectoral approach of the pillars of the PRSP can be another way of monitoring how 'health' in Sierra Leone is being resourced, rather than just 'health care', the former being a main policy objective of the MOHS.

8.3 The PRSP is seen as integrally linked with the Medium Term Expenditure Framework (MTEF) and is intended to guide resource allocation to priority sectors. Together, the PRSP and MTEF are seen as the core of GOSL's planning and budgeting framework. The Good Governance pillar includes activities to strengthen political leadership of the budget process, and ensure accountability through improved financial management and expenditure control mechanisms.

The Medium Term Expenditure Framework (MTEF)

8.4 The Ministry of Finance has issued guidelines for the MTEF approach in Sierra Leone, August 2003. In its guidelines it defines the MTEF in Sierra Leone as, "The MTEF approach can be described as a three year, integrated, broad based, performance rolling-budget that sets out any government's expenditure plans for a three-year period within an available resource ceiling. It integrates both recurrent and capital expenditures, both GOSL as well as donor resources, and is based on achieving an agreed level of performance within each sector. It also places emphasis on three aspects of public expenditure management- Participation, Transparency and Accountability".

8.5 In essence the MTEF consists of a top-down resource envelope consistent with macroeconomic stability and explicit strategic priorities, a bottom-up estimate of the current and medium term costs of existing national priorities and future programmes, and an iterative decision making process that matches these costs with available resources.

8.6 An MTEF is a multi-year public expenditure planning exercise that is used to set out the future budget requirements for existing services and to assess the resource implications of future policy changes and any new programmes. It should be comprehensive, covering all public expenditure and revenues from all sources (including external development partners). Above all the MTEF can improve predictability of resource flows if estimates are based on more realistic assumptions about revenue.

8.7 The MTEF is a tool for achieving greater results from the existing levels of resources, by determining the available resources and allocating these in line with government policies and priorities. The MTEF does not necessarily result in higher levels of resources, but in greater impact from limited resources, it is also involved in matching requirements within sectors and between sectors.

8.8 The Top-down approach will require the estimates of the total resources available and a cabinet decision on how these resources will be allocated between sectors based on Government priorities. Therefore all sectors will need up to date policies and strategic plans. The bottom-up part of the MTEF involves the updating of strategic plans and activity based budgets by the MOHS, boards and districts. The MTEF guidelines lists a number of improvements forthcoming from such an approach, currently the MOHS are benefiting from some and could benefit from others through adoption, Table 8.1 below looks at the possibility of enhanced benefits for MOHS.

8.9 The MTEF budget process results in the preparation of budgets that are based on the achievement of Government's objectives in each ministry. The MOHS is expected to present its annual budget at a policy hearing every year with the aim of discussing and reviewing sectoral policies, this presentation will include expenditure requirements to implement the policies of the MOHS.

8.10 The MTEF process (preparation of strategic plan and costings) provides sufficient information to discuss the costs of policy. Therefore the sectoral ministry is expected to present its policy review reports with three year expenditure requirements at the objective, cost-centre and item levels at the Policy Hearings.

8.11 It may not be necessary to cost every line item required for every sub-component of every activity of every programme for the purposes of an MTEF. This would be unwieldy and of little use to policy makers. However, if the MTEF is supporting the development of

sector support one would expect much greater detail, at least giving broad budget headings, eg. primary level, secondary level, etc. Line budget details need only be included in the annual budgets.

Table 8.1: Top-down and Bottom-up process, benefits for MOHS

Improvements to be gained from Top-down and Bottom -up process of MTEF development	How can MOHS enhance and gain further on these improvements
1. Using a more strategic basis for the budget by reviewing the national and sectoral goals and on which the MDA mission, goals, objectives and outputs should be based	The MOHS needs to approve its current draft policy and develop a strategic national health plan with short term targets and goals.
2. Defining the activities needed to produce the outputs in order to achieve the objectives	The MOHS can strengthen its planning guidelines to districts based on its strategic health plan to ensure that priority areas are addressed, breaking targets down to district level.
3. Basing the budget on the cost of these activities, i.e. moving away from the incremental approach to the preparation of the budget.	A rational approach to planning can be used rather than the current incremental budget planning. This will allow for the major changes that have taken place in relation to infrastructure, staff, population movements, etc. Multi-factored weighted allocation formula can play a major role here. Similarly the updating of all technical/clinical strategies and guidelines to ensure most effective interventions are being promoted.
4. Identifying and costing both recurrent and capital inputs together, i.e. integrating the preparation of the recurrent development budget.	The MOHS through its improved information systems and increased capacity in physical planning can ensure that the balance between capital investment and recurrent costs can be achieved, the MOHS can also be in a position to evaluate any new capital investments in respect to future recurrent budget implications.
5. Planning for and costing donor funded activities so that a broad based plan and budget is prepared.	The MOHS already has established good integration of donor funding into its planning and budgeting process and is increasing the level of integration of NGO funding. This budgeting control could be used as an example to demonstrate the MOHS capacity if self-accounting comes to the line ministries and the possibility of donor untied funds were available.
6. Improving the classification and presentation of the budget so that the cost of achieving the planned outputs and objectives can be seen more clearly.	The MOHS already prepares detailed analysis of budgets down to level of activity. Currently it is difficult for the central MOHS to audit expenditures.
7. Identifying and monitoring the outputs or targets as a measure of performance in meeting the agreed objectives.	As in 1 & 2 above, the MOHS needs to revise its targets to measure its performance in line with its strategic health plan
8. Increased involvement of Vote Controllers in the budget preparation process and emphasising the role of the budget as a management tool	There is need for capacity building both at national and district level. In capacity building for financial management all management staff needs to be considered and not just accounts staff.

8.12 There may be a greater onus on the line departments to cost the services and functions they are responsible for. In practice, the financing of health services is extremely fragmented and there is little data on the unit cost of providing services. Currently resources in Sierra Leone are skewed towards capital costs, which is understandable, but what is the real problem is the over all level of funding is so low.

Salary and drug costs should be the main recurrent items but yet they account for just over half of the recurrent budget.

8.13 The recurrent expenditure can be planned, managed and controlled proactively to reshape the health system in support of priority PHC activities and can improve the overall effectiveness, efficiency and equity of the health services, see allocation formula in the previous chapter. In the future capital and training projects should only be accepted only if their recurrent cost consequences can be accommodated within the planned recurrent expenditure framework.

8.14 The Ministry of Finance has set out guidelines for the presentation of sectoral budgets to MTEF and will make changes to the Budget Classification in the Chart of Accounts to reflect the changes, the following table 8.2 below examines how well prepared the MOHS is to produce it's presentation and what needs to be done or strengthened to do so:

Table 8.2: MTEF Budget Presentation in Annual Estimates Requirements

Title	Content	MOHS
Mission Statement and MDA Objectives	Presents the Mission Statement and objectives for the MDA	Mission statement contained in the National Health Policy, objectives to be developed in the national strategic health plan
Summary by head and sub-head by GOSL - Donor	A summary of the annual estimates broken down by division and broad category of expenditure for both GOSL and donor funds	MOHS is already doing this, system needs to be made more systematic than currently done
Estimate of outputs and objectives	Shows for each Division/Department the objectives and related outputs	Need to develop Hospital and District specific objectives, targets
Summary by MDA, Objectives and item of expenditure	Shows a summary for the MDA of the estimates for the three-year period for the three items of expenditure (Administration, Service Activities and Investment Activities)	MOHS already in a position to redefine its programme expenditures into these new headings
Summary by MDA, head and sub-head	Shows the total estimates for all estimates for all heads and sub-heads for each of the three years	MOHS already doing this in their three year rolling plan
Details of Development Activities	Shows the details of projects including description, costs for the three-years and location	MOHS already doing this, may still be some gaps in relation to NGOs and in future will need to consider the private sector

8.15 The PRSP process affects the MTEF in a number of ways by:

- Increasing revenue flows (by release of HIPC resources, attracting other development partner funding for the strategy)
- Influencing sectoral allocations (towards the social sectors)
- Identifying the policy issues and new programmes required to achieve social objectives – the financial consequences and affordability of which the MTEF process will need to quantify.

8.16 It is proposed that budget monitoring will be carried out by conducting annual Public Expenditure Tracking Surveys (PETS) which will provide quantitative and qualitative evidence on budget execution and accountability and transparency of transactions, to date one has been carried out in health in 2002. In the current Public Expenditure Review being carried out the aspect of drugs is being considered in the health sector. The Public Expenditure Review and PETS can assess the effectiveness of public expenditure and makes recommendations as to how public funds can be better spent.

The Government has also appointed District Budget Oversight Committees comprising of community leaders and representatives of civil society and religious leaders. This is part of the Government's step to empower local communities and not only in the defining of development priorities but also in public accountability of resources used to address those priorities.

8.17 Another way of monitoring the over all use of resources in the health sector is the use of a National Health Account (NHA). A NHA is a tool for gathering and analyzing health expenditure data for a given period. It asks the fundamental questions: who pays, how much and for what? NHAs link ultimate sources of funds to financial intermediaries and claims on spending by different users. "Users" can be classified as providers (e.g. government health centres, or private practitioners), functions (curative, preventive), service delivery level, (tertiary, secondary), inputs (transport, salaries), different socio-economic groups (rural/urban, wealth, gender, age), geographical locations and disease profiles.

8.18 NHAs can and will be used to evaluate many reform policy decisions. Areas that will draw on the NHA include budgetary reform, decentralisation, the evaluation of alternative financing mechanisms, PRSP, and other reform initiatives (public-private mix, contracting). The NHA can confirm and quantify the size and extent of private, and in particular household, expenditure on health. The NHA can provide a comprehensive picture of past funding for health interventions. As a result they can set a baseline on which an MTEF can be built. The MOHS have plans to start developing a NHA as a method of monitoring overall resources in the sector.

8.19 Underpinning the success of the PRSP and the MTEF is the ability to account that funds were spent for the purpose they were intended. Public financial management reform is underway, mainly as part of the public service and devolution process and is being supported through the World Bank and DFID funded institutional reform and capacity building programmes at national and district levels. The major weaknesses of the current public financial management system as identified by the World Bank pre-appraisal team in November 2003 are:

- Budgeting system still does not succeed in presenting a real and comprehensive view on planning and implementation, as well as on monitoring and evaluation;
- The system of internal control and audit is ineffective in line ministries;
- That serious human resource constraints further hampers effective financial management;
- That asset, liability and revenue management does not yet address all related risks;
- That the accounting system have not yet progressed to produce reliable financial statements or meaningful figures for the purpose of budgetary control;
- That the financial management software in use lack critical functionality, controls, audit trails, system documentation and is not accessible for departments;
- That service delivery continue to suffer in the absence of monitoring of results, poor information and a weak control environment in line ministries;
- That external auditing is in arrears and at present still not addressing high risk areas and
- That Parliamentary oversight is not yet effective.

8.20 The main planned activities that will impact on the financial management of the health sector are:

- Establishment of a Public Financial Management (PFM) Reform Implementation Unit
- Correcting the regulatory framework and development and dissemination of a vision of financial management
- The design of new financial management processes and systems
- Financial management capacity building in all line ministries and local governments
- Establishment of interim financial management arrangements for new local governments
- Second phase of procurement reform, which will implement a new national procurement policy, procurement legislation, and regulations.
- The implementation of a new Integrated Financial Management Information System (IFMIS).
- Improvement of internal audit capacity, skills and methods
- Review of the functions and institutional arrangements of the Ministry of Finance
- Improvement of transparency and anti-corruption enablers

8.21 The MOHS, its Departments and Agents (MDA) all have to hold, spend and account for public funds. The level of funding and the capacity to manage funds varies greatly through the system. In the MOHS the Director of Finances and Resources provides the technical capacity for all issues relating to financial management. The Department of Finances and Resources has established a Donor/NGO Liaison Officer's desk, and this tried to capture all different funds flowing through the sector, including NGOs. A large part of the financial management is done on manual systems. While major reforms in financial management are underway as part of the public sector reform process the MOHS has also started to address its own in-house financial management capacity.

8.22 Achievements of the MOHS to date include the

- The preparation of a user friendly accounting manual and takes into account the interest of all sources of funds in the MOHS
- The accounts chart has been revised to accommodate the GOSL structure and format of all donors
- IT specialist contracted to assist with the computerizing of the accounting system
- All project accountants are working together to enhance integration.

8.23 At district level, DHMT staff have been trained in planning and budgeting as part of their district planning. To date the district has only one trained accountant, whom they usually share with the district hospital. There is a great need to build the capacity for financial management at the district level, both in terms of accounts staff and management's capacity to handle funds.

8.24 Recommendations

- Capacity needs to be built in the MOHS at central and district level in Financial Management
- Capacity needs to be built in the MOHS to develop National Health Accounts as a method of monitoring over all use of resources in the health sector

9. Human Resources for the Health Sector

9.1 The health sector is a service driven sector and human resources are probably the single most important input to the sector. Getting the right balance of human resources, in the right place with the right orientation are some of the challenges that all health sectors around the world are facing and Sierra Leone is no exception. The draft national health policy recognises that there is a critical shortage of staff currently working in the health sector both in terms of numbers and range of skills. As of December 2003, according to a MOHS personnel survey, there were 2,404 trained health workers working in the public health services, which provide approximately 70% of the health care in the country. This figure does not include those trained health care workers in the Forces, church, NGO and privately run health care services. Table 9.1 below shows the health worker population ratio for the country. As can be seen staffing ratio to population is heavily weighted towards the Western Area and Bo and Kenema districts. The WHO recommended ratio is one doctor per 12,000 population, only the Western Area meets this recommendation with Kailahun district having a doctor population ratio nearly 25 times the WHO recommendation.

Table 9.1: Trained Health Workers by District, December 2003.

District	Population per health care delivery worker			
	Health Care Delivery Worker (a)	Doctor	Doctor & CHO (b)	Nurse, Midwife & MCH Aide
Western Area	699	10,025	7,315	962
Bo	2,175	61,389	16,250	3,348
Kenema	2,370	54,500	18,167	3,292
Pujehun	3,881	114,500	38,167	5,204
Kambia	2,853	115,750	28,937	4,630
Bonthe	3,735	183,000	22,875	5,545
Bombali	3,824	195,000	55,714	4,643
Koinadugu	3,185	232,500	77,500	4,305
Moyamba	3,477	186,000	33,818	4,593
Kono	4,159	117,833	32,136	6,312
Tonkolili	4,489	197,500	79,000	5,724
Port Loko	5,045	169,833	46,318	6,885
Kailahun	6,255	294,000	36,750	9,484
All Districts	2,099	42,754	20,180	3,032

Note: (a) Includes all health care delivery workers, both skilled and assistants. (b) CHO Community Health Officer. District populations are based on the Statistics Sierra Leone's projections for districts for the Census 2004. Sources: Department Planning and Information, Ministry of Health and Sanitation.

9.2 It should be noted that according to the MOHS staffing records of December 2003 there were 122 Environmental Health Officers (EHOs) in post of which almost half, 60, were posted in the urban Western Area and of the total 712 State Enrolled Community Health Nurses (SECHNs) posted in the public service in the country, 446 (63%) were posted the urban Western Area.

9.3 The current situation is characterized by; a critical shortage of staff (see table 9.2), an unequal distribution of health workers across the country, the range of skills is inappropriate, there are huge economic constraints to increasing the remuneration package of those currently employed or to increasing the total numbers employed, not all the current staff in post are absorbed into the public service (see table 9.3), there is no performance management, the recruitment process is inefficient, there is no national

human resource development plan and there is a growing market for skilled health workers both in the private sector in Sierra Leone and outside the country.

Table 9.2: Staffing Requirements for highly skilled health staff, based on proposed staffing establishment.

	Staff Numbers Required	Existing Staff Numbers	Shortfall	Annual Output of Training Schools
Medical Officers, including specialists	179	106	73	8
State Registered Nurse, including specialised	458	308	150	50
Nurse Midwife	368	42	326	
SECH Nurse	662	712	-50 ⁵	45
MCH Aide	730	726	4	
Pharmacy Technician/Dispenser	122	3	119	40
Community Health Officer	259	132	127	25
Environmental Health Officer	233	122	111	16

Source: MOHS internal documents

Table 9.3: Nursing and MCHAs awaiting absorption into the Public Service

Year completed training	MCHAs	SECHN	SRN
2001	68	0	0
2002	57	49	42
2003	420	51	17
Expected to graduate in 2004	0	40	50
Total	545	140	109

Source: Ministry of Health and Sanitation

9.4 Most of the expansion in staffing over the years has been in Maternal Child Health (MCH), with the training of MCH Aides (MCHAs). There has been no growth in most of the trained staff categories over the last ten years. There is a substantial imbalance in the current skill distribution and with it comes significant problems of supervision and leadership for the individual elements of the health service. Because of a priority of investment in primary health care at community level there has been little attention paid to training of specialists which are necessary to provide referral at secondary and tertiary levels so as to support primary health care, Table 9.2 above.

9.5 There are no target population/health worker ratios in MOHS. While population personnel ratios have their own shortcomings in establishing workload, they are important just to show work burden on personnel and equity of access to trained health workers by the general population.

Staff Establishment and Actual Staff

9.6 Currently the MOHS is working on creating staff establishments for the different types of health facility in the country, until this is done there is no clear means to calculate the current discrepancies between actual staff in post and required. The level of vacancies for trained staff varies but it is compounded in that health facilities have been redesignated over time, i.e. either down-graded or up-graded due to physical

⁵ Although there appears to be adequate SECHs this must be viewed in the context that not all SECHs are doing the job of a SECH due to non-availability or inadequate availability of other nursing cadres, hence SECHs are being used to fill the role of other nursing cadres. In addition the majority of SECHs are working in the Western Area.

change or staff losses. The situation for the CHASL health facilities is fairly similar so that, as a whole, the institutions of the health sector are uniformly understaffed for all its cadres of trained staff, but it is unclear on what criteria the shortage is being quantified.

9.7 The MOHS has done staffing projections for staffing of Peripheral Health Units (PHUs) in the country. There were 730 PHUs before the war in Sierra Leone, there are now 655 functional. There is a target stipulated in the primary health care handbook of a PHU for every 5,000 of population. Therefore the PHU staffing projections have been done on population basis only. Table 9.4 shows the recommended staffing by level of PHU, and table 9.5 shows the vacancies of staff with the current PHUs and with the total number of required PHUs according to MOHS target.

Table 9.4: PHU recommended staffing standards

	CHO	EHO	SECHN	MCHA	EDCUA/VAC
Community Health Centre (CHC)	1	1	1	1	1
Community Health Post (CHP)			1	1	1
Maternal Child Health Post (MCHP)				1	1

Source: Primary Health Care Handbook 1997, MOHS

Table 9.5: Vacancy Analysis for current and required PHUs

Cadre	No. of PHUs	Total Recommended posts	No. in Post	Vacancy Current PHUs	Vacancies with required PHUs (a)
CHO	CHC 220	220	128	92	588
EHO		220	12	208	678
SECHN	CHP 200	420	96	324	794
MCHA	PHU 730	730	500	230	700
EDCUA/VAC	PHU 730	730	148	582	1,052

(a) Vacancies calculated by Department of Planning and Information if MOHS targets are to be met

Source: adopted from OCHA report, January 2003, Internal MOHS memo on staffing shortages, February 2004.

9.8 The results of the MOHS projections showed that except for CHO vacancies all cadres cannot be filled in the next 10 years given current training outputs. The possibility of achieving full CHO posts is also questionable since the role of CHOs is changing and it is being recommended that their training be changed so that they can do more curative work and therefore they may be required to staff secondary level facilities in the future.

9.9 Table 9.5 above shows large vacancies of trained staff at the primary health care level. This means that most PHUs are manned by untrained volunteers. In addition many NGOs have recruited qualified personnel but there are no arrangements for their absorption into the public service after the life of the NGO projects, so there is lack of sustainability of services. Current human resource data collection and information systems are weak and do not take account of trained staff working with non-government providers.

9.10 While there are no up to date figures on staff losses, there is every reason to believe that the rate of loss is continuing, or possibly rising. The loss rate is high and, given the existing numbers of staff in the service, significant proportions of newly trained staff will be taken up with filling vacancies created by losses rather than adding to the level of staffing. The issue of losses goes beyond simply numbers of staff; it also impacts on the overall skill and experience in the service. The Ministry is concerned that increasing training capacity will not be the only solution to stem the tide of losses.

Training of health workers

9.11 Training of health workers takes place as basic and post-basic (which incorporates external and in-service training). Basic training is delivered through an array of institutions primarily within the Ministry of Education, MOHS and CHASL, see Table 9.6 below. In addition once off courses are run for the training of MCHAs. In the past there has been seven hospitals designated for training MCHAs and they have trained 420 MCHA.

TABLE 9.6: BASIC TRAINING PROVIDERS IN SIERRA LEONE

Institution	Courses	Annual Average output
College of Medicine and Allied Health Sciences	MB BS Medical Degree -6 years training, plus pre-med	8
	B Pharm -5 years (don't graduate every year)	n/a
	BSc Nursing -3 years (started 2003)	n/a
The National School of Nursing	State Registered Nurse (SRN) -3 years training	50
	State Enrolled Community Health Nurse (SECHN) -2 ½ years training	45
National School of Hygiene*	Diploma Environmental Health Officer (EHO) -3 Years training	16
Paramedical School*	Certificate Community Health Officer (CHO) -3 Years training	25
School of Pharmacy	Pharmacy Technicians -3 years training	40
Forces Nurses Training School	State Enrolled Community Health Nurse (SECHN) -2 ½ years training	40
Nixon Memorial School of Nursing	State Enrolled Community Health Nurse (SECHN) -2 ½ years training	30
Mattru School of Nursing	State Enrolled Community Health Nurse (SECHN) -2 ½ years training	30

*Note: The MOHS has agreed that the school of hygiene and the paramedical school will merge and this will be the first step to a full transfer over to the Tertiary Education Commission of the University of Sierra Leone.

n/a : not available

9.12 The drop-out rate in the training schools ranges from 5 -17% per course. The main problems being experienced being:

- Tutor shortage
- Inadequate funding, and late receipt of funding
- Insufficient teaching aids and materials
- Inadequate library facilities
- Lack of refresher training for tutors
- Inadequate training facilities for students for practicals
- Inadequate transport for student supervision during internship

- Lack of electricity and water, generally poor accommodation.
- Inadequate communication facilities.

9.13 Post-basic training is one of two types: In-service training provided at service centres within Sierra Leone or advanced training provided through educational institutions in Sierra Leone or, more frequently, through donor-sponsored training in institutions elsewhere. The MOHS has prioritised the sending of officers to regional centres for post-basic training, as a measure to ensure that they will return once completed.

9.14 The overall analysis of health worker training is that training is driven primarily by individual interest and initiative with little post-training mobilisation of the acquired skills directed at improving the performance of the institution from which the staff come:

- Utilization of specialized personnel often does not correspond to their particular skills training.
- Most of the external specialised training offered by the Ministry is generally driven by individual requests, rather than by an analysis of organisational requirements.
- There is no training plan or policy.
- There is limited capacity in basic training schools, which is manifested through infra-structure problems, specifically limitations of classroom, office and hostel facilities
- Clinical training is hampered especially in the teaching hospital
- Tutor shortage: Almost all schools are experiencing some difficulty in providing qualified tutors and preceptors.

9.15 Standard of facilities is poor and therefore inadequate for training purposes. People need to be trained in an environment where workers are well-motivated, drugs and supplies are available and the appropriate infrastructure and equipment are available. There are reports that it is now difficult for MCHAs to see the required number of normal deliveries at PHUs during their practical training, as most women deliver at home and only come to PHUs with complications, this can be seen both positively and negatively and must be seen in the Sierra Leone context in that the overall management of pregnant women is not effective and thus results in a high maternal and infant mortality rate.

Underlying issues of the Human Resources situation

9.16 The current issues relating to human resources in the health sector, in terms of availability and training, has been described together with a range of problems associated with the current situation. While it has been possible to quantify some of the problems described in terms of staff numbers, mix, geographic distribution, vacancies, etc, the underlying characteristics of the problems appear to lie more in issues emerging from:

- Inequities in: pay and benefits, promotion opportunities, professional development, posting and deployment, recognition and reward,
- Uncertainties about: career opportunities, corporate and individual purpose and objectives, inter/intra organisational roles, relationships and responsibilities.
- Managers without the means of management
- Organisational processes inflexible, out of date and geared to administration and not the needs of a managed service

- Inadequate numbers and skills in management disciplines
- Labour market opportunities for the more highly skilled staff

9.17 However, the need for basic training in isolation without addressing the wider organisational problems across the health system may be both inefficient and ineffectual. Inefficient in that it simply contributes to larger numbers leaving the service and expensive in comparison to adopting new personnel policies directed at retaining existing staff and, ineffectual in that it may not by itself solve the distribution and service problems.

9.18 The difficulty facing the MOHS is two fold: firstly, there is a pressing need to address perceived shortages in key staff groups (e.g. doctors, nurses and midwives) and funding to meet existing service demands; and, secondly, a need to introduce new approaches to the training, deployment and management of the health sector workforce which can lead to improved service to, and health of, the population.

9.19 The problem for the MOHS is that it is, on the one hand, currently bound by existing essentially administrative public service regulatory processes and procedures that inhibit both the nature and speed of action possible to address current workforce problems; and, on the other, inadequate or insufficient information, management capacity and organisational structures to properly assess the situation, develop a rigorous approach to current and future problems and monitor and evaluate outcomes leading to further action. Of major importance will be the introduction of the Local Government Services Commission, as part of the devolution process. This will mean the delinkage of staff from the Public Service Commission, initially it is planned that all staff will remain seconded in their current posts for two years. But the possibilities of addressing the staffing distribution imbalance should be considered at every opportunity.

9.20 Despite this environment and the many years of unrest, staff in the health sector have continued to give service: but, it is not surprising that they are increasingly demotivated and are seeking better circumstances for themselves irrespective of the costs and benefits to the service. The consequence is increasing numbers moving out of the public health service to other agencies and other countries or completely out of the health sector to other forms of employment. However, there are many strategic interventions to rectify the situation that have been tried and evaluated in other countries, which can be tried for the health sector as a whole in Sierra Leone to consider.

Human Resource Development in the Health Sector

9.21 The concept behind a managed health service is that it is performance driven, with performance defined in terms of: efficiency, effectiveness, equity, appropriateness, accessibility and acceptability. While all these dimensions are equally important, most attention has been reserved for the three 'e's of efficiency, effectiveness and equity in the provision of services. They are likely in the short term to be the primary focus of development initiatives in the health sector. However, little of the systems or processes are currently in place to pursue these objectives and the creation of the local government services commission and the potential transfer of staff to this commission will further mean the need for strong sectoral human resource policy.

9.22 Projections show that the demand of trained health workers cannot be met unless the intake is increased and the dropout rate and attrition are reduced. This entails among other things, increased budgetary allocation to MOHS and more investments in health personnel training schools. While it is good to build new PHUs to increase

geographical access to health care it is also true that access is based on several factors of which appropriate staffing is core.

9.23 Together with these developments comes a requirement to determine through whom and by what means these initiatives can be managed. As a consequence, the organisational relationships between the different stakeholders of the health sector concerned with human resources development will need to be defined and developed, particularly in the light of decentralisation and the introducing of the Local Government Services Commission working in association with the MOHS and the Public Service Commission. The MOHS are currently considering the establishment of a Directorate of Human Resources. Whether this is established or not it is important that the MOHS strengthens its institutional capacity to provide effective policy in relation to human resources for the health sector.

9.24 Recommendations

- The overall level of funding for human resources in the health sector needs to be increased, both in absolute and allocative terms, this includes basic and post-basic training facilities and conditions of service
- Issues of retention of existing staff must be urgently addressed, particularly the absorption of staff into the public service
- Need to develop a national human resources policy and plan for the health sector
- Need to strengthen support to address the non-pay elements of staff motivation and conditions of service, particularly staff housing and working environment

10. Procurement

10.1 In Sierra Leone all Government procurement is overseen by the National Tender Board, with line ministries having their own procurement units, with an authorised ceiling on value of tenders they are authorised to deal with. Overall Government rules and regulations on procurement are changing with the development of a new procurement act. It is being proposed in the Act that the general framework for procurement will be a National Procurement Board with representatives at district level, line ministries will retain a procurement function, but for some ministries its role is not clear. The forthcoming devolution is likely to have an impact on the procurement process, since the procurement function at district level will become the domain of District Council.

10.2 In general, the MOHS assumes its role after devolution to be a regulatory and policy setting one; yet, its roles and responsibilities specific to the procurement system also need to be defined. In the MOHS it needs to be resolved how tertiary hospitals and national training institutions, still under the MOHS control, even after devolution, will be dealt with. The MOHS are involved in the development of the Procurement Act and the implications of the Act on current practice in the MOHS and districts needs to be closely monitored and communicated. The MOHS has made its comments and recommendations which aim to avoid decentralisation of drugs procurement to district level, because of the disadvantages entailed by such a solution.

10.3 Currently, the District Health Management Teams (DHMTs) do not play a major role in procurement. District procurement is limited in the amounts of medical and non-medical consumables purchased. With the implementation of devolution, the districts are likely to play a more active role in procurement. With this increased responsibility, the managerial capacity of the DHMT to carry out efficient procurement will need to be developed. At the same time, the Ministry's function will shift from the current role of a direct purchaser on behalf of districts to an advisory and supervisory one. The capacity of the Ministry, therefore, needs to be developed accordingly.

10.4 There are three areas of procurement that are likely to be retained by the central MOHS; the procurement of civil works, drugs and medical supplies and technical assistance. These are discussed below.

Procurement of Civil Works

10.5 The draft health policy of the MOHS states that the Government is committed to ensuring that appropriate infrastructure is available to support the provision of priority services, being primary and secondary care, while acknowledging the need to rehabilitate and maintain a level of tertiary level facilities.

10.6 The MOHS has an Architectural Services Unit (ASU) and a Facility Maintenance Unit (FMU). These units are concerned with all capital investments in both civil works and equipment. They have responsibility for national coverage, though the ASU was initially staffed to support the World Bank Health Sector Rehabilitation and Development Project; however it now is involved in almost every civil works covering almost all districts in the country. These units also work with church and NGO providers. Both units are under resourced for the amount of work which they have to do, both in terms of human resources, financial support and appropriate working facilities.

10.7 The current arrangements for procurement of civil works also involves the Ministry of Public Works, as this ministry has the responsibility of national overview on all civil works. The main sources of funding for civil works at present are the World Bank, African Development Bank, European Union and HIPC funds. Current building portfolio

covers the construction of district hospitals, community health centres, storage for Central Medical Stores, and rehabilitation of tertiary hospitals, training schools and community health centres.

10.8 The MOHS does not have a physical assets management policy, but it does have a handbook on building standards for health facilities by level, staff housing and this handbook sets targets for type of facility by population. There are also some standards set for medical equipment to be used in the MOHS. One of the main concerns is the recurrent budget to maintain both the current and new infrastructure. This is a major concern in Sierra Leone, given the high level of building activity and the constraints on all other inputs such as staffing, drugs and medical supplies and recurrent budget.

10.9 While a large building programme is expected in Sierra Leone after years of damage and lack of repair to most facilities it is also important for the MOHS to start monitoring how its current investment in infrastructure is being used. There is a tendency to forget about the capital invested in previous years and whether it was a worth while investment. One of the easiest ways to monitor this is through utilisation rates of the facilities, particularly hospitals. During this review utilisation rates, particularly in bed occupancy rates, reported in districts were low, one 50 bedded district hospital had two admissions in the month of February. This is a concern and needs investigation.

10.10 Recommendations

- The ASU and the FMU should be supported in building their capacity, particularly to further develop the policy framework to guide the implementation of investment for all civil works for the sector.
- To ensure the cost effectiveness of investment in infrastructure there is a need for a more detailed analysis on the ability to fund its recurrent costs and this should to be considered in the feasibility of any new investments.
- There is need to monitor how past investment in infrastructure is being utilised, and issues identified addressed

Procurement of Drugs and Medical Supplies

10.11 It is the policy of the MOHS to ensure that there are appropriate levels of resources to operationalise the Pharmacy and Drug Act (2001). The policy recognises that the provision of good quality care is dependent on the availability of safe and affordable medical supplies. It is also the role of the MOHS to ensure public safety from all drugs and this it does through the Pharmacy Board through licensing and inspection.

10.12 The main organisational structure in the MOHS for the procurement, storage and distribution of drugs and medical supplies is the Central Medical Stores (CMS). The objective of the Central Medical Stores is to ensure that drugs and medical supplies are *continuously* available in the health facilities. At present this does not appear to be working efficiently for a number of reasons.

10.13 At the national level CMS is obliged to follow Government procedures, which are generally highly bureaucratic. All drug procurement is done by the Procurement of the MOHS, with limited involvement of the CMS technical staff. The rules and regulations used by the MOHS to manage, control and supervise the CMS are of themselves not necessarily consistent with a more efficient functioning of the organisation. However,

persistent shortages of qualified staff, availability of funds and other resources mean that the CMS is not able to respond adequately to the needs of the health facilities.

10.14 In particular, the main problems that the management of CMS has to deal with are:

- Insufficient control over financial resources (resulting in recapitalization and cash-flow problems);
- Insufficient control over the tender process (resulting in a lengthy process and changed outcomes), lack of availability of foreign exchange for international purchases, currently all MOHS funded procurement is done by the Procurement Unit in the MOHS; and,
- Insufficient control over human resources (resulting in a mismatch of capacities and capabilities).

10.15 At the district level there are district drugs stores, which operate as a holding store between CMS and the PHUs, there are no trained pharmacists in the majority of districts, so the system is managed by dispensers and druggists at district level. There is a system of cost-recovery in place for drugs. A recent Government policy announcement stated that 60% of the population were vulnerable and should not pay for drugs. Therefore the districts are requesting PHUs to recover 40% of the cost of the drugs supplied. No mechanism has been put in place to fund the 60% exempted or to monitor if 60% is the level of exemptions needed to meet the needs of the vulnerable in the community.

10.16 It was the finding of this review that there was generally a lot of confusion among health workers on how this cost-recovery and exemption policy was to work. In many of the PHUs visited they were using user-fees to replace the cost of the exempted drugs so that you could reorder drugs. In one PHU visited the in-charge was trying to recover the total value of the drugs received before reordering, despite the fact that many drugs had been dispensed free-of-charge and there was no possibility of recovering the full value with the existing depleted stocks, so the shelves were empty and what money collected to date was sitting in the bank at the district.

10.17 The current practice is that district pharmacy receives requisitions from the PHUs, these requisitions are prepared by the PHU in-charge and authorised by the Chairperson of the Community/village development committee. This is a control system in place since the introduction of the Bamako Initiative.

10.18 The evaluation of the requisitions by the district pharmacy is not always based on the actual need of the PHU for the simple reason that this is not always known. PHU requisitions are largely guided by the balance of their funds collected through cost-recovery. No standard consumption profiles have been determined as to date; because of regular stock-outs, it is difficult to rely on historical consumption data. As a result, drug orders from the districts and health facilities do not necessarily reflect real consumption. For CMS as well as for the district pharmacies it is therefore extremely difficult to forecast the drug requirements. The big lesson being learnt with the current system is that the real cost of 'free' drugs is the lack of drugs and disillusionment by the community.

10.19 The overall lack of transport in many districts means that regular distribution to the health facilities is not always possible. As most health centres do not maintain a buffer stock, infrequent or delayed supplies immediately result in stock-outs.

10.20 At the PHU level, many in-charges have difficulties calculating their drug and medical supplies needs as a result of poor stock management capacities and the uncertainty of supplies may cause over-ordering. At all levels, the lack of reliable data on the consumption patterns makes it extremely difficult to maintain accurate budgets and orders. This is because most of the inventory control system is still done manually and makes management of the whole stock of drugs and medical supplies very difficult, and turns procurement forecasting into an art rather than a science. Currently there is no proper quality control system in place.

10.21 Main sources of funding for drugs and medical supplies currently are the GOSL, EU, UNICEF and internally generated funds from cost-recovery. In 2003 the planned CMS budget for drugs and medical supplies from all sources was Le8.152 billion, the actual expenditure, according to MOHS records, was Le2.351 billion, this amount to approximately Le.466 per capita or approximately US\$0.20 per capita⁶. The planned budget for 2004 is Le. 10.1 billion or Le. 2000 or US\$0.80 per capita. It is probably unrealistic to expect that this target of expenditure will be reached this year. Whether this target is reached or not it must be looked at in absolute terms in that it falls well below the WHO target of US\$1.20 per capita expenditure on drugs for the provision of basic health care and the MOHS budget includes specialist drugs also. Estimations for future funding for drug supply in the country vary from US\$1 million to US\$3 million per annum. Until more is known about the present value of the current revolving fund, and more information to predict future demand and supply capacity, it is difficult to estimate future funding requirements with any certainty.

10.22 Internal generation of funding for drugs is currently in place and likely to continue in the future. A cost-recovery scheme is an attempt to mobilize financial resources based on a demonstrated willingness of people to pay for health services and in this instance for their drugs. Pre-war years cost-recovery level on drugs reached 60%, but this has fallen drastically both during and post war. Tertiary hospitals have maintained a 40-50% level of cost-recovery. There are many problems to be addressed if a revolving drug fund is to be maintained based on cost-recovery, the need for good information and analytical tasks such as; assessment of the potential market size and type, estimation of the costs of the revolving fund, establishment of the cost-recovery objectives and definition of the role of subsidies and surcharges, estimating future drug requirements, either consumption-based, service based, or population-based, work is also needed on determining operating costs, including salaries, facility costs, utilities, etc.. Some of these issues can be addressed in the development of health financing policy, discussed in chapter 7, especially cost-recovery objectives and the other issues need to be considered in relation to other reform processes such as the project to strengthen CMS. Current reform processes are detailed below but what is clear is that all these areas currently require strengthening.

10.23 There are public and political aspects to drug supply which also need to be considered, especially the issue of exemptions from payment for drugs. The role of subsidies and surcharges are important and establishing a pricing policy is not as simple as it seems. Political, social and patient preference issues frequently enter into the cost-recovery and exemptions process. Popular subsidy targets considered by policy-makers in Sierra Leone includes drugs for mothers and children, drugs for elderly or medically indigent, proven preventive measures (e.g. immunization), and high mortality diseases with costly but effective treatments such as TB. Subsidisation of certain portions of the population or certain categories of drugs requires charging higher prices for the remaining population's drugs (surcharge) unless these are subsidised through other

⁶ Population is based on Statistics Sierra Leone's projects for the Census 2004. Exchange rate is done at current rate of US\$1 equals 2,500 Leones.

payments, which currently does not happen in the health system. The current Government policy on exemptions and the MOHS's strategy on cost-recovery for drugs are not mutually supportive.

10.24 There are a number of major reforms currently underway to address the issues raised above, which includes:

- Development of statutory instrument on the legal status of CMS
- Infrastructure development
- Computerisation of systems
- Revision of the national drug policy, national formulary, essential drug list.
- Capacity building for management
- Development of appropriate information systems
- Capitalisation of CMS
- Strengthening of quality control

10.25 The main institutional reform is the granting of CMS autonomy. The exact nature of this is not yet agreed and is still in the development and discussion stage. But it is agreed that in the future CMS will be a commercial operation and not a public service. If CMS moves towards a commercial orientation and way of working then it will need to be certain of its operating costs and ensure adequate mark-up and turn-over to sure viability and sustainability of operations. There is strong political will for the commercialisation of the CMS and for the adoption of a business like approach.

10.26 The issue of quality control is also being addressed with the construction of a new laboratory, the training of staff, and the setting of standards and the implementation of a quality control mechanism. These reforms in CMS are being supported through the EUs Health Sector Support Project and by a loan from the African Development Bank.

10.27 Any expansion on access and provision of drugs and medical supplies in Sierra Leone must be done in a coordinated way so as to ensure effectiveness and efficiency, and ultimately continuity and sustainability of supply which is affordable to all.

10.28 Recommendations

- Overall funding for drugs and medical supplies needs to be increased, especially in light of future capitalisation of CMS
- There is an urgent need to review the operations of the current drug supply system both at national and district level and recommend changes that will as a priority address the issue of continuity of supply of essential, quality and affordable drugs at district and PHU level.
- All future Government and Ministerial policies and strategies must be assessed for compatibility and impact on accessibility and affordability, especially for those most vulnerable.

Procurement of Technical Assistance

10.29 Technical Assistance (TA) is an important component of external support, especially in financial terms. Currently the procurement of TA is largely determined by the development or funding partners, and is predominately project-based. There are no national guidelines for the procurement of TAs, nor are there standard national contracts

for TAs (TAs contracted directly by MOHS) does not exist. It is important that the MOHS treats the procurement of TA as any other input, setting out standards, reviewing applications, etc. It is the practice of many development partners to contract out the management of their support to consultancy companies who have to bid with pre-nominated named TA. This may not work out satisfactorily for all parties and the MOHS should insist on being involved in the interview and selection process for all long-term TA. In a human capacity constrained environment the MOHS should consider designating TA as 'officers' rather than 'advisers'. The term officer orientates towards an extra pair of hands getting the job done rather than just sitting and advising. Short-term TA is also generally project or externally driven and is rarely in response to expressed needs of the MOHS.

10.30 Support to the sector from development partners is changing and more and more there is a tendency to move towards central budgetary support rather than sectoral support, this change is a core objective of the MTEF process. Therefore there will be less support with ear-marked TA budgets and the MOHS needs to plan for how it will resource the MOHS with both long and short-term TA in the future.

10.31 There is a large pool of TA already in the country when one considers the UN agencies, NGOs, teaching institutions, other ministries and individuals. Some of these are well engaged within the MOHS but largely they serve the needs of their own agency. Better use could be made of this pool of TA by more effective use of taskforces and working committees.

10.32 In the future the MOHS should consider some of the following ways of addressing the procurement of TA:

- Develop a databank of TAs for short-term assignments
- Clearly identify TA needs as an input into action plans and budget for it.
- Ensure full MOHS involvement in the selection and appointment of TA, long-term in particular
- Develop a standard contract for the employment of TA making it clear that the MOHS is the purchasing agent
- Make more appropriate use of the TA in partner agencies, especially the UN agencies and the NGOs.
- Consider setting up a TA-fund as a line item in the MOHS budget from which TA will be procured.

10.33 It is important to remember that TA is an expensive input and often because the cost of the TA is not openly discussed, for a number of reasons, it is not considered like other inputs in terms of value for money, output, usefulness, etc. But like all goods it consumes scarce resources which has alternative uses and needs to be effective.

10.34 Recommendation

- Need to strengthen the role of the MOHS in the identification and procurement of TA

11. Environment, Nutrition and Health

11.1 The Ministry of Health and Sanitation (MOHS) has the executive authority for waste management, inside as well as outside the health-care facilities, in Sierra Leone. The Environmental Health Division of the Ministry currently has the direct responsibility of waste management in the country. This Division is therefore responsible for improving the sanitary conditions of the population by providing the enabling environment for safe solid waste and excreta disposal, as well as access to safe and adequate water supply.

11.2 Over the years the proportion of the population with access to safe water and to proper sanitation has gradually declined. This decline is especially marked in the rural areas. Problems about the environment, water and sanitation have not been dealt with in a coherent manner. This is largely so because the mandate for these areas have been moved from ministry to ministry over the years.

11.3 The Ministries of Lands, and Agriculture, have had at different times the responsibility for the environment. While the Ministry of Health carries responsibility for environmental health, there seems to be no concerted mechanism for coordination with the other Ministries responsible for the environment.

11.4 Recently, an Environmental Protection Board, which is multisectoral, has been established in the Ministry of Lands and the Environment. It is expected that this Board will play a coordinating role with respect to issues relating to the environment.

11.5 With respect to environmental sanitation, the MOHS has carried direct responsibility. In the Western Area, this responsibility was temporarily entrusted to a contracting firm under the supervision of the Ministry. This arrangement did not work to the satisfaction of the Ministry and it was consequently changed.

11.6 To ensure community participation in environmental sanitation, a National Cleaning Day was instituted, and enforced throughout the country at the beginning of the 1990s. The health authorities, including the MOHS, closely supervised this exercise. Recently this National Cleaning Day has been abolished, and the responsibility for environmental sanitation has been transferred from the MOHS to the Ministry of Youth and Sports.

11.7 Ideally responsibility for environmental sanitation should be given to the municipal and local government authorities in the various Districts and Regions. The Ministry of Health and Sanitation should maintain the oversight function and provide directions with respect to the effect and impact of sanitation on the health of the population. Similarly, the Ministry responsible for the environment should carry these functions with respect to the impact of sanitation on the environment. The two Ministries should establish linkages to agree standards for environmental sanitation.

11.8 Apart from dealing with the problem of environmental sanitation, the MOHS has to ensure the safe disposal of medical and health waste. The topic of safe health-care waste management is not specifically dealt with in the Public Health Ordinance Act No. 23 of 1960 nor is it contained in the present Environmental Protection Act No.2 of 2000. However, the MOHS is addressing the issue of manage of clinical solid waste through support from the World Bank, this support is being used to both address the production of waste and its disposal and the MOHS are in the process of developing a hospital waste policy. The MOHS is also working in collaboration with the NAS on issues of safe-disposal in relation to contaminated sharps.

11.9 Infectious or communicable diseases are the major causes of morbidity and mortality in Sierra Leone. Most of these diseases can be transmitted by unhygienic

waste handling, not only in the health-care facilities amongst the patients and staff, but also in the community, if the waste is openly exposed.

11.10 To prevent and control these infectious diseases, it is essential to have measures in place for effective environmental sanitation and safe health-care waste management. While it is important to strengthen the existing curative health delivery system, it is necessary for the health care delivery system to focus on the development of preventive services, such as the proper management of sanitary health-care waste.

11.11 Responsibility for the provision of safe water is also not restricted to one Ministry. While the Ministry of Health and Sanitation is responsible for the health aspects of water, responsibility for the actual availability of water is shifted to the Ministry of Energy and Power. A systematic approach to ensure that an adequate supply of safe water is available to the whole population is yet to be developed. An attempt in this direction, has however, been made in the Ministry of Energy and Power by constituting a Technical Committee on Water and Sanitation. This committee provides a forum for regular consultations among stakeholders for water and sanitation.

11.12 Recommendations

- There is need to support the implementation of the policy on health care waste management once it is approved.
- There is need to formulate policy on water and environmental sanitation, to ensure the availability of adequate supply of water, and proper disposal of waste.

Nutrition

11.13 There is a department of nutrition in the Ministry of Health and Sanitation. This department is responsible for developing and supervising all nutrition activities within the Ministry. Malnutrition is a major cause of childhood mortality and an important contributory factor to deaths in the population. Children under five years account for 17% of the population. The interaction between nutrition and infection among children and their mothers is of great concern in Sierra Leone. In fact it is estimated that about half of all deaths in children are attributed to malnutrition.

11.14 A national nutrition survey established that 24% of under five year old children studied were moderately malnourished while three percent of them suffered from severe malnutrition, this study was conducted over 20 years ago and there have been considerable changes (for the worse). The recent Multi-Indicator Cluster Survey (MICS 2000) showed that the Underweight prevalence in U5 children is currently 27.2%, wasting (acute malnutrition) prevalence in U5 children is 9.8%, while the prevalence of stunting (chronic malnutrition) is reported as 33.9% in the same population group. Acute malnutrition affects particularly children under two years of age, while its prevalence decreases after that age. Chronic malnutrition also increases considerably during the first two years of life, and gradually further increases after that age.

11.15 The poor nutritional status of pregnant women is further related to the increasing number of children born with a low birth weight (LBW). The proportion of LBW babies has increased significantly from 11% to about 53% during the last decade. Poor nutrition care practices include inadequate breastfeeding and complementary feeding. Breast-feeding is clearly the natural method of feeding infants everywhere. Exclusive

breastfeeding is recommended for the first 4-6 months of life. During this period the baby should be given only breast milk and nothing else: not even water. In a recent (2003) evaluation of safe motherhood activities in four districts virtually all the women reported that they started breast feeding their children. About 90% of them started within 24 hours of delivery. In fact over 60% of them did so within the first hour after delivery. More than half of those who did not initiate breast feeding early said they fell ill soon after delivery of the child.

11.16 While 97% of the mothers were breast feeding at the time of the study, no child benefited from exclusive breast feeding. In fact 71% of the mothers said they gave their children water to drink right from the first day of life. Eighty five per cent of the new born babies had received water to drink by the time they were about a week old. This is in agreement of the MICS 2000 which showed that only 2.5% of infants less than 4 months old were exclusively breastfed. More than 75% of the children had received water or other liquids, while 15% had already consumed solid food.

11.17 There are three major determining factors leading to malnutrition:

1. Immediate causes, these causes are attributed to
 - Inadequate food intake
 - Disease
2. Underlying causes, these causes are attributed to
 - Poor household food security
 - Lack of adequate health care
 - Lack of adequate maternal and child health care
3. Basic causes, usually embedded in
 - Cultural
 - Economic
 - Social and political factors.

11.18 The main focus of nutrition activities is to improve the nutritional status of the population, especially of children, pregnant women and mothers and other vulnerable groups, and prevent malnutrition in these groups. At the local and community levels nutrition activities are carried out within the context of PHC in the PHUs. At the hospital the activities are carried out at the MCH clinics.

11.19 In collaboration with UNICEF, WHO, WFP, and other partners, the MOHS is contributing to the establishment of a national household food security and information system. There is now great attention directed to combating micronutrient deficiencies in the country. Pregnant women are targeted for the administration of iron and folic acid, while children aged between 6 months and 5 years are targeted for Vitamin A supplementation. Micronutrient deficiency also greatly contributes to the prevalence of chronic malnutrition. In women poor nutritional status is associated with micronutrient deficiencies. It is thus estimated that 86.7% of pregnant women suffer from anaemia, about 70% of which is associated with malaria, and the rest owing to iron and foliate deficiencies.

11.20 An estimated 40% of children under-five years suffer from Vitamin A deficiency. Despite mass campaigns during the National Immunization Days, Vitamin A supplementation reached only 64% of the children under-five and 33% of the women after delivery in 2000. These figures have only marginally improved. In another study conducted to assess the extent of iodine deficiency disorders among school children in

selected districts of the country it was shown that 12%, 32% and 53% of the children had mild, moderate and severe disorders respectively.

11.21 As a result, Government agreed on the policy of importation of only iodized salt, and of making provision for the iodization of locally produced salt. Despite such a policy, the consumption of iodized salt was reported in only 23.4% of households, with consumption rates as low as 5% in areas where local salt production is common.

11.22 On the whole, Government is committed to improve the nutritional status of the population. This has been expressed at the highest political level in the call to achieve national food security by 2007. Following this call, the process of developing a National Plan of Action for improving nutrition was entrusted to a multisectoral and multidisciplinary taskforce. The Action Plan includes an analysis of underlying issues, objectives, policy measures and responsible agencies in a wide variety of sectors. Government has also committed itself to enhance improvements in maternal, infant and under-five care in terms of expanding the coverage of and access to quality health services.

11.23 Efforts of the MOHS are complemented by WFP and NGOs, which support and provide opportunities for supplementary and therapeutic feeding of malnourished children in PHUs across the country. Highlights of the National Plan of Action for food and Nutrition, as they relate to nutrition, are attached in Annex 5.

11.24 Recommendations

- Formulate national nutrition policy
- Strengthen nutrition education activities; in particular introduce nutrition education into the curriculum of schools and other training institutions
- Establish a surveillance system for monitoring the nutrition situation in the country. This should include a periodic national nutrition survey
- Promote breastfeeding and proper weaning practices with appropriate local weaning foods
- Strengthen the elimination of micronutrient deficiencies
- Train relevant staff in food and nutrition technology

12. Partnership

12.1 Partnership between government, donors, providers and consumers in the health sector was given a boost when in September 1992, all stakeholders were brought together in a one-week seminar. This event triggered a series of consultations, dialogue, and discourse resulting in the production of the National Health Policy of 1993, and the National Health Action Plan of 1994 amongst others. One of the establishments resulting from this effort was the setting up of the Donor/NGO Liaison office within the MOHS. This office was charged with the responsibility of coordinating Donor/NGO activities in the sector and as well as providing good communication between all parties. This office functioned for some time but became less effective during the escalation of rebel activities in the country, but has now been re-established with the appointment of a new head.

Health Sector Aid Co-ordination

12.2 There are various levels, at which different institutions active in the sector, are coordinated;

- a) Central Aid Co-ordination unit at the Ministry of Development and Economic Planning (MODEP). This has overall responsibility for aid co-ordination and management, based on clearly drawn guidelines which include:
 - Registration of Donor Agencies and NGOS operating in the country
 - Setting up of the national development policy
 - Has responsibility for donor contact and co-ordination.
- b) Donor/NGO Liaison Unit at the MOHS. This unit has the overall responsibility for providing the necessary linkages between all stakeholders within the sector. It is also responsible for the registration of all NGOS operating in the sector.

12.3 The office of the Donor/NGO – liaison at the MOHS must be used as the focal point for all communication and activities relating to donors and NGOs. This office should be further strengthened to improve linkages and communication with all stakeholders. It should have the capability to collect and process data which will provide the basis for the Annual Review and Annual Report. To do this it should develop a prototype to be submitted for discussion and approval by stakeholder. This standard form should be simple and easy to fill, but detailed enough to capture all the necessary inputs required to the annual review. This data collection should be completed quarterly and the MOH should be able to do a quarterly analysis, and participants should be provided with a quarterly report. Apart from ensuring transparency, and the complete sharing of information right across the sector, it will alert participants of unforeseen problems that may require corrective measures prior to the year end review.

Types of Partnership

12.4 There are various types of partnership, largely dictated by the size of the institutions. Large multilateral and bilaterals have Memorandum of Understanding (MOUs), mostly signed with the Ministry of Foreign Affairs. These agreements determine how they operate even at sectoral level. Smaller institutions are registered with the MODEP and the MOHS. Guidelines for sectoral donor and NGO support should be revised. It should provide options that they feel comfortable but working in tandem with proposed programs agreed upon at the annual review and planning meeting. An important partnership which has been overlooked at least in terms of formal arrangements is the Public/Private partnership. This has been an oversight which needs

to be addressed. The private sector needs to be looked at from the role of the private for profit and the private not for profit, i.e. the church and NGO providers. Currently, the Christian Health Association of Sierra Leone (CHASL), which is the umbrella organisation for all Christian church health providers, is responsible for delivery of over 20% of the health care in the country. However, the MOHS and CHASL have no formal agreement in either the form of a code of conduct, contract agreement or MOU. The private sector could be made to play a much bigger role especially in the area of service delivery. This role should be explored and formalized.

12.5 Recommendations

- The donor/NGO liaison unit in the MOHS needs further strengthening and support.
- Working arrangements for all sectoral partners should be revised and standardized into a joint code of conduct or MOU for the sector.
- Arrangements for engagement with the private sector should be formalized, especially CHASL.

13. Alternative Health Providers in Sierra Leone

13.1 There are three main alternative health providers in the country affecting community and personal health. They are:

1. Spiritual Healers of various religious denominations
2. Traditional Healers
3. Private Medical Practitioners

13.2 In addition there are *itinerant peddlers* of orthodox medicines of doubtful quality and efficacy loaded in portfolios. These are the quack doctors known locally as Pepper Doctors and are in the far corners of the heart of the hinterlands. In these areas they are the only medical personnel known. They pose danger to the unsuspecting public, while the more daring ones operate on hernias. The wonder is that they receive licenses from the City council and other civic authorities. These quacks thrive only because the distribution of our trained staff in relation to the health needs of the people in the rural areas is a monstrosity for the disparity it engenders

13.3 Their competitors are the ubiquitous herbalists with their baskets full of medicinal plants claiming to cure all diseases. These medical systems exist side by side in a state of Drugs they carry in their brief cases are mostly expired drugs, badly preserved, and may even be fake ones. Some have been known to inject milk into baby's arms.

The Spiritualist Healers

13.4 These have become pre-eminent recently in this country. The Church of our Lord Aladura, the Adejorby church, Church of Salvation, Pentecostals and a host of prophets, moray men from various mosques are all involved in the healing process. Indeed televangelism through the radio and television have introduced a bit of modernity to the whole spiritual scene.

13.5 Religious healing is not new; it is at the basis of many world religions. Religious sceptics like Sigmund Freud considered it as an escape into the oceanic feeling in which the faithful are apt to lose sight of the shores of reality. The rituals, taboos, and observances serve as a collective compulsion neurosis, which at best may serve the individual from developing a compulsive neurosis of his/her own. Pro-religious people like Carl Jung claim that it is needed as an outlet for the unruly forces of the collective unconscious. It channels these forces into dogma and ritual and thus serves as a safety valve for the "Perils of the soul" that would otherwise threaten to disrupt man's personality.

13.6 But to the spiritualists and their congregations, religion represent a mystic union with God, a promise of redemption from sin, a gateway to the spiritual goal which transcends the boundaries of rational human experience. Sin becomes the ultimate cause of most human suffering. In this the Scriptures guide him. James 5 verse 13-15 clearly states "*Is any one of you afflicted? Let him pray...Is any sick among you? Let him call for the elders of the Church; and let them pray over him, anointing him with oil in the Name of the Lord: And the prayer of faith shall save the sick and the Lord shall raise him up, and if he had committed sins they shall be forgiven.*"

13.7 It is not surprising that the churches and Mosques became sanctuaries during the Rebel war. They were the solitary solace at that time for the doomed.

MOH point of view they represent a cheap form of medical care. They are accessible to every one, affordable and no harm has been reported. With only limited facilities for dealing with the neurotics, epileptics, chronically sick these religious revivals help to rehabilitate these people.

Traditional Healers

13.8 Medicine, music, and sculpture represent the traditional healers' ancient and passionate tryst with the supernatural. That is why the three are always present during the healing process especially the chronic cases.

13.9 In the sculpture, the precious genius of the African carver at least to foreign eyes, is his scorn of reality. Here is beauty that does not care one whit about reproducing nature's forms. In fact it is not beauty that the carver is trying to create, it is an attempt to communicate with the spirits, to prevent them from doing evil, to win their benevolence, and help to keep harmony in the rhythms of life and to fend off the terrors of the unknown. What foreigners see in a Mende Nomoli statuette is a work of art. What the Mende carver saw was an object of worship with a sacred role to play: to protect the rice farm or crops. The statuette or Masks represent the incarnation of a terrible combat of supernatural forces.

13.10 The music too has a subtle appeal-its earthiness and sensuality. When drummers begin to pound their instruments, blood flowing through the sick responds with a rhythm of its own. The feet of the dancers stir more than dust. Here the Healer, the sick and the audience are all locked in a participatory trance.

13.11 Traditional herbal medicine too embodies this same earthiness in forms, material and physical participation. In the traditional cosmology, for any medicine to be effective, it must be imbued with extrinsic magical powers. This is why the healers carry around an array of statuettes, tom-tom drums and other bric-bracs of piety. Above all is the use of the spoken word. It is by the rhythmic incantation of the word that the healer invokes the vital force. The vibrating effect of the spoken word accompanied by the percussion instruments achieves a communal participation whether in the religious activity or the healing process

13.12 Traditional healers, carvers, and musicians are not a small set apart class to serve a spectator public. Craftsmanship is part of traditional life no one will dream of avoiding. Just as a man hunts so too does he carve, dance, play a musical instrument and participate in the care of the sick. Some are better than others, but its matter of degree not of separateness. Villages are proud of their best or renowned healers, carvers, musicians; but their eminence do not stem from their originality. Instead the aim has been to preserve faithfully the ways of the past.

Engagement of Traditional Healers

13.13 There is a subtle classification of diseases into two broad categories by the rural people, hospital diseases (white man disease) and native disease. This classification helps them decide whether to seek a native Healer or go to hospital.

White man's diseases are effectively cured by European medicine:

- Sores, wounds, malaria pneumonia, yaws
- Operative procedures of many descriptions
- Infectious diseases such as STI.

Native diseases are considered as better managed by a healer:

- Psychosomatic diseases, Insanity
- Broken taboos:
 - (a) Allergic diseases
 - (b) Marked weight loss, convulsion, delirium
- Witchcraft diseases
 - a) Accidents
 - b) Obscure illness
 - c) Loss of consciousness
 - d) Acts of God-lightening, thunder victims of storms drowning
 - e) Attacks by wild animals, leopard, baboon
 - f) Witch sore chronic cancerous lesions.

13.14 All these diseases are thought to imply soul pathology. The white man is outside of this picture neither affected by nor able to cure native diseases. Our people consider the white man's medicine as impersonal, amoral and incomplete. It is descriptive, but not explanatory. It says a person died of liver tumour but not why it happened to him/her. European cultures, as part of their scientific revolution, had long ago separated the curative from the moral functions,

The role of women

13.15 The woman's place in traditional healing should be appreciated. She is the midwife, gynaecologists, paediatrician, general practitioner and acts as the surgeon in the female secret society.

13.16 The woman's work as a birth attendant is always closely aligned and is sponsored both formally and informal by the secrete society. The society forms the central pillar of dependability amongst the women. It carries out the entire responsibility for training and social indoctrination of the female side of the community. Membership of the society is an index of one's full membership of the community and one's readiness to assume adult responsibilities.

13.17 There is no statistics as to the number of TBAs but a rough estimate can be made since three miles are all a TBA needs to travel to see her patient and vice versa. So there will be a TBA working within every three mile radius suggesting a large number of TBA practitioners. Another way to calculate the number of TBAs is one TBA for 300 people, used by UNICEF, 1996. For the current projected population of 5.5 million it would mean that there are over 16,000 TBAs. TBAs carry out 70% of the deliveries in the country.

The role of men

13.18 The man is not ordinarily called to treat female and children diseases unless they are thought to be due to witchcraft. He usually has treatment for specific diseases: leprosy, insanity, tumours and snakebites. He is the orthopaedic surgeon where he may reveal consummate skill in bone setting. The idea is to get a useful limb rather than perfect alignment. Amputations are unheard. There is a well-developed traditional pharmacopoeia.

What have we learnt from traditional medicine?

13.19 Since the slave trade when the African continent was ravaged by pestilence, tribal warfare and her most productive population carted off to the Americas, the African

population was at a standstill. Many were slaughtered during the colonial times. Yet the population stood still. This feat was due to the efficiency of the Traditional healers.

Table 13.1: Population growth by continent 1650-1900

	1650 (‘millions)	1750 (‘millions)	1850 (‘millions)	1900 (‘millions)
Africa	100	100	100	120
Europe	103	133	274	423
Asia	257	437	656	857

Source: Walter Rodney in "How Europe Underdeveloped Africa", pg 97

13.20 In spite of these achievements, traditional medicine suffers severe setbacks.

Magi co- mystical outlook-This has been a main barrier to the integration of traditional medicine and orthodox medicine. It is asking too much for a scientifically trained doctor to believe in the curative value of sacrifice, magic spells, curse, dances and incantations. These even if they are efficacious will be difficult to verify scientifically and what is more to replicate.

Midwifery Practice Training of TBAs has been going on in West Africa in order to lower the maternal mortality in the region. Unfortunately this has not had an impact. Their role is to deliver babies and when a calamity strikes, and then it is the will of God or the outcome of a terrible combat with supernatural forces. Expiciation of the Gods is the only remedy and the more bizarre the event the more terrible must be the supernatural force that caused it

13.21 Government, working through the medical profession and the Traditional Healers Association (THA), need to pay more attention to traditional healers in order to bring them under the umbrella of organised medical practice. Integration of the two services is out of the question, since the two professions are under a different ethos of medical service delivery and jurisprudence. There is need however, to standardise their herbal dosage forms and prolong the shelf life of the concoctions. Their training needs to be monitored as many quacks are springing in their midst. Some of the medicinal forms have highly toxic alkaloids and torpenoids that are hepato-toxic. Their animal gallbladder extracts are very poisonous and embodies much of the traditional toxicology. Funding is needed to strengthen the THA so that they can help Healers set up pharmacies of local medicinal plants and animals.

13.22 Traditional healers should be used as listening posts for the outbreak of infectious diseases; treating simple illnesses, trauma and mental diseases. Attraction of traditional healing is its cheapness. Every patient no matter how poor has access to and can afford a healer.

Private Practitioners

13.23 These are part and parcel of orthodox medicine and consist mainly in the Sierra Leone context of (a) Retirees (b) Foreign Doctors (c) Sierra Leone doctors unwilling to join the Government medical services (d) Doctors in Government medical services.

- Retiree every member of the medical profession who retires from government service is entitled to set up private practice.
- Foreign Doctors anxious to set up private practice are allowed to do so only when in partnership with Sierra Leonean counterparts.
- There is nothing to stop a suitably qualified Sierra Leonean from setting up private practice any where in the country.

- Medical personnel in Government services.

13.23 Because of Government's inability to pay adequate salaries to the medical staff, every employee is allowed private practice. In turn there is tendency for individual employees to privatise the public sector. All these offer fee for services. Only patients who can pay go to private practitioners. Practitioners are not primarily concerned with the alleviation of poverty; they look and cater for the affluent. At present there are no specialist engaged in full private practice in the rural areas, only in the urban areas.

13.24 Private Practitioners deal with the wealthier portion of the population who would otherwise impinge upon the subsidised cost recovery of the public health services. To expand the role of private practice in Sierra Leone it might be beneficial for Practitioners to learn how other countries are organising their private health care. For example:

- Group practise where many practitioners group together to share staff, theatre facilities, bed space and clerical staff. This in the long run is cheaper as costs are shared. This is along the line of Managed Health Care now spreading in North America with modification of course.
- Pharmacies established by GPs will ensure quality control, use of standard drugs. There are too many drug peddlers in the business with cheap faked brands or expired ones. There are too few pharmacists in the country to supervise the many drugstores mushrooming all over the country.
- Encourage the establishment of Health Insurance for those who can afford the insurance premiums.
- Group practice of this nature will attract internal and external funding as Doctors forgo the makeshift arrangements currently in vogue for a well run or managed institutions by professional health managers.

13.25 Recommendations

- The MOHS needs to strengthen its collaboration with traditional healers
- The role of private health care need to be further investigated in Sierra Leone and strategies developed for its development.

14. Monitoring and Evaluation

14.1 Accountability and transparency are key principles of the Government of Sierra Leone, and fundamental to the growth of the democratic state. Monitoring and evaluating the Government's involvement in the health sector is critical to ensuring that core objectives of Government and sectoral policy are being implemented.

14.2 Monitoring and evaluating has to start with the setting of goals, objectives and targets, and then agreeing on suitable indicators to measure the progress towards achieving them. Collection of indicators will require both routine and non-routine methods of collection. It is also important that indicators are evaluated and their interpretation feeds back into revising the goals, objectives and targets.

14.3 There are currently a large number of strategic and technical policies approved by the MOHS. Some of them have specific targets to be reached. The MOHS has identified key national health sector performance indicators and specific health related Millennium Development Goal indicators. The performance indicators look at overall percentage allocation of public funding to the health sector and its absorption, numbers of facilities and training schools functioning, and some indicators on immunisation and health outcome patterns, e.g. maternal mortality and contraceptive prevalence rate. There are no indicators set to monitor the key policy goals of equity and access. Data currently collected is not disaggregated, except by age in some disease information systems.

14.4 The collection of indicators to measure progress requires a number of routine and non-routine data collection systems, the following are some of the systems of use to the health sector in Sierra Leone currently in use:

Routine systems

- Health Management Information System
- Integrated Disease Surveillance
- HIV/AIDS Sentinel Survey
- Annual Report of the MOHS
- Three-year rolling strategic plan
- Disease programmes own information systems

Non-routine systems

- Integrated Household Living Conditions Survey
- National Population Census
- Research and surveys

14.5 A critical problem in the Sierra Leone health sector is that the routine data system is not comprehensive and existing systems are not performing effectively. Information systems are lacking in many areas, especially commodity logistics, human resources and finances. The use of National Health Accounts is discussed in chapter 8 as a method for monitoring overall resourcing of the sector.

14.6 Routine and non-routine sources of information, both within and outside the health sector, provide an abundance of data related to health and health care. Yet, to collect and use data in an adequate manner, and to assess the overall performance of the health sector, by linking input- process- output- and outcome data provided by the various management systems and research, remains a formidable challenge.

14.7 Non-routine systems such as research and surveys are largely based on project and development partners' priorities or on academic imperatives; there is often

insufficient consideration of Sierra Leonean health information needs and priorities and frequently the case that discussion and dissemination of findings are insufficient, especially in the local context; consultancy reports, in particular, frequently fail to be properly taken into account in planning. As a result there is an under utilisation of evidence-based findings to inform policy and decision making.

14.8 Health systems research should be seen to be crucial for PRSP and health sector strengthening, to the extent that it is complementary to routine management information systems in providing evidence to shape decision-making across the functional domains of prioritisation, implementation, monitoring, and evaluation. So far, there appears to be no national agenda set by MOHS for health systems research.

14.9 There is a need to consider different forums for the dissemination of routine and non-routine data collections findings. This needs to be considered in the context of the overall management and planning cycle of the sector, and the role of monitoring and evaluation in the sector.

14.10 There is a need for regular annual consultative meetings on the sector. This should not just include top policy and decision makers but should be supported by mechanisms to report back on an annual basis on the state of health of the nation to the people in the districts. Use could be made of the proposed new governance structures, district councils and their committees, and further use made of the existing community and village development committees. It should be a goal of an information system to be able to feed back to an individual as to how progress on the implementation of national policies to address their needs are being met. It is an objective of the draft health policy to meet the needs of the community for information.

14.11 Establishment of a unified health management information system has remained a priority of the MOHS for some time, but this needs to be guided by an overall policy on information and its use in the health sector and should be seen as a prerequisite and fundamental for all monitoring and evaluation of the sector.

14.12 Recommendations

- All policies and strategies should be revised to ensure that they have monitoring indicators that are gender, age, equity and poverty specific.
- Need to develop and implement a technical policy on information in the health sector
- Capacity needs to be strengthened at all levels to ensure utilisation of data systems
- The emerging governance structures need to be fully engaged in the monitoring and evaluation of the sector

15. Main Recommendations and Implementation Arrangements

The main recommendations of this health sector review are presented in the matrix below. The following steps to guide implementation of the health sector support to the PRSP are proposed as:

Next Steps:

1. Agree the findings and recommendations of the sector review with the sectoral stakeholders.
2. Ensure that the MOHS's current strategic planning sufficiently addresses the policy, strategy and resource gaps identified in this review and that the budgets proposed in the MOHS three-year rolling plan are sufficient to implement these recommendations.
3. Based on the priorities agreed by the MOHS and its stakeholders reprioritise based on predictions of filling the resource gap, when future resource envelope is better known.

Implementation Arrangements

- The MOHS currently has a deconcentrated management, planning and budgeting system in use. It will be important that future implementation arrangements will build on this capacity.
- The governance structures proposed under devolution will provide excellent opportunities for ensuring increased participation at district and sub-district levels for the management of resources to health as well as ensuring that local priorities are being addressed. It is also important to strengthening the role of the existing finance and development committees.
- The proposed development and revision of MOHS policies and strategies should ensure greater equitable distribution of resources and this will need to be supported by stronger sectoral planning, budgeting and monitoring arrangements as proposed under the MTEF and the public finance reforms.
- The MOHS are engaged in all public reform processes and any additional resources to the sector will need to be guided by strong sectoral policy and managed and accounted for by the emerging transparent government systems.

Matrix of review recommendations:

Area of Review	Recommendation	Action Steps	Timing	Policy/Strategy/Plans and other reference documents
Poverty	<ul style="list-style-type: none"> • Additional resources need to be made available to fight the most common diseases, ensuring that prevention strategies are prioritised. 	<ul style="list-style-type: none"> • Monitor level of funding released to carryout PHC activities by programme • Advocate for agreement that the funding gap for PHC activities will 	<ul style="list-style-type: none"> • On-going • In time for 2005/2006 	National Health Policy MOHS Three-year strategic rolling plan

Area of Review	Recommendation	Action Steps	Timing	Policy/Strategy/Plans and other reference documents
		have first call on any new funds	budget	Individual strategic plans of technical programmes
Equity	<ul style="list-style-type: none"> The MOHS must ensure that all its strategies have targets that address the equitable distribution of resources to meet those most in need in the country. All indicators used to measure progress of strategies need to be monitored on a regular basis and action taken to address findings. 	<ul style="list-style-type: none"> Need for MOHS to review the implementation of all its strategies to ensure that the issue of equity is being addressed The MOHS needs to ensure that the annual reporting system is capable of feeding back to districts on issues of distribution of all resources The MOHS should advocate for the formation of an equity monitoring group, made up of NGOs, civil society organisations and private sector to support the MOHS to independently monitor equity within the health service 	<ul style="list-style-type: none"> 2005 as part of review of 2004/2005 workplan Annually as part of a district annual review process To be proposed as part of the NGO liaison activities, 2005 	<p>Three-year Strategic Rolling plan</p> <p>Annual MOHS Reports</p> <p>District Workplans</p> <p>District Reports</p>
Gender	<ul style="list-style-type: none"> Conduct a national study on maternal mortality to determine the extent of the problem Promotion of effective Reproductive Health services, incorporating male involvement Removal of barriers to the utilization of 	<ul style="list-style-type: none"> Need to form a taskforce to coordinate a study to validate the MMR and to examine factors contributing to MMR in SL Revise and develop protocols to ensure male involvement in SRH Establish a taskforce to review 	<ul style="list-style-type: none"> 2005-2006 Early 2005 Early 2005 	<p>Propose carrying out of Demographic Health Survey</p> <p>Reproductive Health Guidelines</p> <p>Review of programme reports, research studies</p>

Area of Review	Recommendation	Action Steps	Timing	Policy/Strategy/Plans and other reference documents
Gender (continued)	<p>health care services</p> <ul style="list-style-type: none"> • Public education for the promotion of elimination of harmful traditional practices • Policy: Review National HIV/AIDS Policy, formulate Gender Policy and National Reproductive Health Policy • Collect and present data disaggregated by sex to ensure that gender concerns are addressed 	<p>findings from all stakeholders on barriers of access, especially for women.</p> <ul style="list-style-type: none"> • Establish guidelines for use at community level on civic education on harmful practices • Lobby for establishment of inter-ministerial committee to formulate national gender policy. MOHS to establish taskforce to develop national RH policy • Revise current HMIS to disaggregate data by sex and ensure that all future data is disaggregated 	<ul style="list-style-type: none"> • Mid-2005 • Mid-2005 • Later-2005 	<p>National Policy on Gender Mainstreaming</p> <p>National Policy on the advancement of Women</p>
Policy and Legislation	<ul style="list-style-type: none"> • A National Health Action Plan should be designed with programs to address the policy objectives within a specific time frame e.g. 5 – 8 years. This will serve as the reference document guiding District planning and the 3– Year Rolling Plan. • There is a need to develop technical policies for all priority areas that currently do not have one, and a need to develop a system for revising existing technical policies on an ongoing basis. • It is recommended that priority be given to the overhauling of the legal framework for health. An all-inclusive new 	<ul style="list-style-type: none"> • Discuss feasibility of need of developing national strategic plan with stakeholders • Establish technical working group to review all standard treatment guidelines being used in the country • Prepare a cabinet paper for presentation outlining the need 	<ul style="list-style-type: none"> • Late-2005 • Mid-2005 • Late 2005 	<p>Draft National Health Policy</p> <p>Public Health Ordinance</p> <p>Local Government Act</p> <p>Standard Treatment Guidelines and protocols</p>

Area of Review	Recommendation	Action Steps	Timing	Policy/Strategy/Plans and other reference documents
	ordinance should be formulated. In doing so the current legal documents, the National Health Policy and the new local government ordinance should form the working documents.	for revision of the public health ordinance		
Organisational Structure	<ul style="list-style-type: none"> • Need for the MOHS to adapt and adopt the new Organizational Structure proposed by the recently concluded Management and Functional Review of the Ministry • Need to ensure that the MOHS role in environmental health, and in particular sanitation, is reflected in the MOHS's organisational structure • Need to clarify the organisational linkages between the newly formed Hospital Boards and the central MOHS 	<ul style="list-style-type: none"> • In collaboration with DPs review implementation of organisational reforms • Hold consultation meetings to discuss practical implications of change in roles and responsibilities and establish mutually agreed linkages 	<ul style="list-style-type: none"> • Early 2005 • Early 2005 	Health Boards Act Public Service Reform Programme
Health Financing	<ul style="list-style-type: none"> • Policy, there is need to develop a comprehensive health care financing policy. • Resource Mobilisation and allocation, there is a need to increase overall resources to the sector and a need to ensure greater allocative and technical 	<ul style="list-style-type: none"> • Once HSSP supported Health Finance TA is in post appoint a taskforce to work on development of national health financing policy. This taskforce may need to commission a number of studies to inform the development. The taskforce should have clear ToRs • Need to work in close collaboration with Health Financing taskforce and with the Ministry of Finance in the 	<ul style="list-style-type: none"> • Early 2005 • Early 2005 	Draft National Health Policy Local Government Act Household Cost of Living Survey 2004 Standard Treatment Guidelines and protocols National Census 2004 (when completed)

Area of Review	Recommendation	Action Steps	Timing	Policy/Strategy/Plans and other reference documents
Financial Management	<p>efficiency in resource allocation, by developing allocation formula.</p> <ul style="list-style-type: none"> • The MOHS should establish a taskforce to work on estimating the future unit cost of services. • Capacity needs to be built in the MOHS at central and district level in Financial Management • Capacity needs to be built in the MOHS to develop National Health Accounts as a method of monitoring over all use of resources in the health sector 	<p>development of district allocation formula based on multiple socio-economic criteria. The taskforce should have clear ToRs</p> <ul style="list-style-type: none"> • Need to draw up terms of reference for a taskforce to coordinate the work to establish unit cost of services for the MOHS • Work with current public service reform and strengthening projects to determine the capacity needs at central and district level in relation to financial management • Support Planning Department staff to attend regional training on National Health Accounts, at the same time MOHS, with support from WHO, should advocate with other DPs for adoption of NHAs as a sector monitoring tool 	<ul style="list-style-type: none"> • Mid-2005 • Mid-2005 • Late-2005 	<p>Draft National Health Policy</p> <p>Local Government Act</p> <p>World Bank and DFID support programmes</p>
Human Resources	<ul style="list-style-type: none"> • The overall level of funding for human resources in the health sector needs to be increased, both in absolute and allocative terms, this includes basic and post-basic training facilities and conditions of service 	<ul style="list-style-type: none"> • MOHS should develop an emergency plan of action to address current HR problems, including budget for absorption of staff, increase in basic training capacity and measures to increase conditions of service, especially staff housing in rural areas. 	<ul style="list-style-type: none"> • Begin as soon as possible, some elements will take longer time frame 	<p>Draft National Health Plan</p> <p>Local Government Act</p> <p>Public Service Reform documents</p> <p>Standard Treatment Guidelines and protocols</p>

Area of Review	Recommendation	Action Steps	Timing	Policy/Strategy/Plans and other reference documents
Human Resources (continued)	<ul style="list-style-type: none"> • Issues of retention of existing staff must be urgently addressed, particularly the absorption of staff into the public service • Need to develop a national human resources policy and plan for the health sector • Need to strengthen support to address the non-pay elements of staff motivation and conditions of service, particularly staff housing and working environment 	<ul style="list-style-type: none"> • MOHS should place priority on the use any new funds to absorb staff currently in the service on to the payroll • MOHS working with HSSP support should accelerate the current work being done on HRD towards the development of a comprehensive HRD plan for health • MOHS need to advocate with Ministry of Finance and DPs for new funding to address non-pay elements of staff motivation 	<ul style="list-style-type: none"> • Mid-2005 • As soon as possible • Early-2005 	
Procurement of Civil Works	<ul style="list-style-type: none"> • The ASU and the FMU should be supported in building their capacity, particularly to further develop the policy framework to guide the implementation of investment for all civil works for the sector. • To ensure the cost effectiveness of investment in infrastructure there is a need for a more detailed analysis on the ability to fund its recurrent costs and this should be considered in the feasibility of any new investments. 	<ul style="list-style-type: none"> • MOHS should consider the development of a capital investment plan for longer -term civil works and a policy to guide its implementation, following the current phase of emergency rebuilding of facilities • The MOHS needs to ensure that the criteria for proceeding with any new investment in infrastructure are based on the MOHSs ability to fund its recurrent requirements, which criteria could be contained in a policy document for capital 	<ul style="list-style-type: none"> • Late-2005 • Early 2006 	National Procurement Act (under development) Local Government Act

Area of Review	Recommendation	Action Steps	Timing	Policy/Strategy/Plans and other reference documents
	<ul style="list-style-type: none"> There is need to monitor how past investment in infrastructure is being utilised, and issues identified addressed 	<p>investments.</p> <ul style="list-style-type: none"> The ASU and the FMU should as part of its annual reporting monitor utilisation rates of facilities , as well as reporting on budget allocations for routine maintenance of plan and equipment 	<ul style="list-style-type: none"> Mid-2006 	
Procurement of Drugs and Medical Supplies	<ul style="list-style-type: none"> Overall funding for drugs and medical supplies needs to be increased, especially in light of future capitalisation of CMS There is an urgent need to review the operations of the current drug supply system both at national and district level and recommend changes that will as a priority address the issue of continuity of supply of essential, quality and affordable drugs at district and PHU level. All future Government and Ministerial policies and strategies must be assessed for compatibility and impact on accessibility and affordability, especially for those most vulnerable. 	<ul style="list-style-type: none"> MOHS need to advocate for continuing support from DPs on strengthening and implementing the CMS reform process MOHS with HSSP support to continuously monitor and review current flow of drugs and medical supplies in the health system MOHS to ensure that exemption policies designed to increase access for vulnerable groups are implemented and a mechanism for covering the costs of exempted drugs and supplies is put in place so that districts are not penalised for exempting patients. 	<ul style="list-style-type: none"> Ongoing Ongoing Ongoing 	<p>Draft National Health Policy</p> <p>Bamako Initiative Operational Guidelines</p>
Procurement of	<ul style="list-style-type: none"> Need to strengthen the role of the 	<ul style="list-style-type: none"> MOHS to establish core 	<ul style="list-style-type: none"> Ongoing 	

Area of Review	Recommendation	Action Steps	Timing	Policy/Strategy/Plans and other reference documents
Technical Assistance	MOHS in the identification and procurement of TA	competency requirements for all TA and ensure that TA supplied meets the requirement		
Environment	<ul style="list-style-type: none"> • There is need to support the implementation of the policy on health care waste management once it is approved. • There is need to formulate policy on water and environmental sanitation, to ensure the availability of adequate supply of water, and proper disposal of waste. 	<ul style="list-style-type: none"> • Once policy is developed MOHS to carryout dissemination of the policy and develop strategy or guidelines for its implementation • MOHS to advocate with other related ministries for the formation of an inter-ministerial taskforce 	<ul style="list-style-type: none"> • Mid-2005 • Later 2005 	
Nutrition	<ul style="list-style-type: none"> • Formulate national nutrition policy • Strengthen nutrition education activities; in particular introduce nutrition education into the curriculum of schools and other training institutions • Establish a surveillance system for monitoring the nutrition situation in the country. This should include a periodic national nutrition survey • Promote breastfeeding and proper weaning practices with appropriate local weaning foods • Strengthen the elimination of micronutrient deficiencies 	<ul style="list-style-type: none"> • MOHS to establishment multi-stakeholder taskforce to develop national nutrition policy • MOHS to solicit funds to carryout national nutrition survey and for the setting up on routine surveillance systems through out the country • MOHS to analysis all district health plans to ensure that nutrition issues are adequately addressed in district plans 	<ul style="list-style-type: none"> • Mid-2005 	Multiple study reports on nutrition through out the country

Area of Review	Recommendation	Action Steps	Timing	Policy/Strategy/Plans and other reference documents
	<ul style="list-style-type: none"> Train relevant staff in food and nutrition technology 			
Partnerships	<ul style="list-style-type: none"> The donor/NGO liaison unit in the MOHS needs further strengthening and support. Working arrangements for all sectoral partners should be revised and standardized into a joint code of conduct or MOU for the sector. Arrangements for engagement with the private sector should be formalized, especially CHASL. 	<ul style="list-style-type: none"> MOHS to assess the support needs of the donor/NGO liaison unit and advocate for support MOHS to discuss issue of joint MOUs with partners through existing forums As CHASL is such an important partner in terms of health service provision the MOHS should develop detailed agreements on service delivery 	<ul style="list-style-type: none"> Early-2005 Ongoing Mid-2005 	National NGO Policy
Alternative Providers	<ul style="list-style-type: none"> The MOHS needs to strengthen its collaboration with traditional healers The role of private health care need to be further investigated in Sierra Leone and strategies developed for its development. 	<ul style="list-style-type: none"> The MOHS should set up a forum for ongoing dialogue with the traditional health sector The MOHS should commission a study to review the role of the private sector in the health sector in Sierra Leone 	<ul style="list-style-type: none"> Late 2005 Early 2006 	Traditional Healers Bill
Monitoring and Evaluation	<ul style="list-style-type: none"> All policies and strategies should be revised to ensure that they have monitoring indicators that are gender, age, equity and poverty specific. Need to develop and implement a 	<ul style="list-style-type: none"> The MOHS needs to develop a number of filters that all policies, strategies and planned activities should be put through, namely capacity to achieve, impact on poverty, equity and gender, etc. MOHS needs to coordinate the 	<ul style="list-style-type: none"> Mi-2005 Late-2005 	Local Government Act Hospital Boards Act

Area of Review	Recommendation	Action Steps	Timing	Policy/Strategy/Plans and other reference documents
	<p>technical policy on information in the health sector</p> <ul style="list-style-type: none"> • Capacity needs to be strengthened at all levels to ensure utilisation of data systems • The emerging governance structures need to be fully engaged in the monitoring and evaluation of the sector 	<p>development of an information policy within the ministry, once developed there needs to be an assessment of capacity requirements to implement it.</p> <ul style="list-style-type: none"> • The MOHS needs to assess the role of all the new management and coordination committees in relation to their role and level of responsibilities in the monitoring of the sector 	<ul style="list-style-type: none"> • Late 2005 	

Annex 1: Terms of Reference

There are overall ToRs for the three sector reviews, health, education and agriculture; these are the ToRs specifically for Health

Health Sector Review and Strategy Development

1. **Background:** Unlike in other sectors, a significant amount of background research has been undertaken in the health sector, which have been used by government to guide planning. One such study was the Multi – Cluster Indicator Survey (MICS II), the results of which were utilized during the preparation of the IPRSP. This trend has continued after the end of the war, and the results of these recent studies continue to guide the policy formulation and planning processes in the health sector. There are, however, significant information gaps that need to be filled in to provide a more complete assessment of the sector needs.
2. **Objective:** The objective of the support required is to assist with the review of current activities in the health care sector, make recommendations on changes based on the new poverty data and assist with the costing of any new programmes. The areas with information gaps that need to be urgently addressed are Health Care Financing and Sustainability and Health Legislation. Recommendations will stem from the findings of these studies, outlining long – term programs and activities to address identified deficiencies. The study should start from an overview of the available information including the results of the PPAs, FGDs and HIES.
3. The team should comprise technical experts in the following fields *Health Economics and Health Care Financing and Health Legislation and Control*. It is expected that at least one national expert will be recruited in each area of specialty to provide support for the work of the international consultants. Experience in Sub – Saharan Africa, especially in West Africa generally and in Sierra Leone in particular, will be an added advantage for all international consultants.
4. *Health Economics Specialists:* In close collaboration with the Directorates of Planning and Information and of Financial Resources, and taking into consideration the recently completed (but narrow scope) Public Expenditure Review of the health sector, the specialists will be expected to conduct the following:
 - Analysis of the operating budget (Allocations and actual expenditures) by level of facility.
 - Estimation of the unit cost of services.
 - Analysis of the cost recovery systems, including community involvement in health care financing.
 - Based on the findings of the above, proposals on feasible options for cost – recovery and of a management plan for funds by level of facility, culminating in the design of appropriate cost – recovery system(s).
 - Assist the Ministry of Health with the development of the Medium Term Expenditure Framework and PRSP Sector programme based on the relevant data resulting from the HIES, the PPAs, FGDs and PETs.
5. Qualifications required include a degree in economics with post – graduate qualification in economics. Minimum of 15 years post – qualification experience, especially in management accounting and budgetary control, primarily in a health care environment; at least 5 of these years should have been in a senior management position.

6. *Specialist on Health Legislation:* The specialist will be required to review the various laws controlling the health care delivery services with a view to update them. This will be implemented in consultation with the Law Officers' Department, with special emphasis on the following:
 - Analysis of the legal provisions relating to medical practice, especially the registration of medical practitioners.
 - Analysis of the legal provisions relating to the operation of health care institutions.
 - Study of the laws relating to medical ethics, especially in clinical research.
 - Review of recent enactments in health care to ensure that they are reasonably comprehensive and effective.
 - Based on the findings, make recommendations to update all health legislation accordingly and outline steps to establish machinery for the monitoring of implementation to ensure effectiveness country – wide.
7. Basic qualification in Law and Legislation, with post – graduate training in administration and management, preferably with a health bias. A minimum of 10 years post – qualification experience, with at least 5 years in the field of health legislation.

Other Relevant Information:

8. The bidders should be aware that there are currently two large projects being developed in the Health (World Bank \$20m; EU €30m), both of which are intending to strengthen managerial capacity. It will be important for the consultants to liaise with the Project Teams for both projects as appropriate.
9. In addition, the consultants will be required to stay abreast of decentralization and public sector reform initiatives as they relate to the Ministry of Health.
10. Bidders should also be aware that both UNICEF and WHO have indicated their intention of supporting the Health Sector Review, but have yet to specify the type of support that they will be willing/able to provide. It will be important for the Consultants to liaise with these UN Agencies to ensure coherence.
11. Bidders should also be aware that there are a large number of International NGOs working in this sector and will be expected to liaise with them as appropriate

Annex 2: Analysis of district consultations.

Issue	Responses
1. Is government providing enough services to address the health needs of the community?	<ul style="list-style-type: none"> • No, insufficient range of services • No, not enough CHOs, distances too far to CHCs, just basic services • Poor human resources management, inadequate trained and qualified staff, lack of support staff • Inadequate drugs, equipment and other medical supplies • Poor transport and communication systems, poor roads network • Poor monitoring and evaluation system • No decentralisation • Inaccessible, user fees too high • Inadequate access to clean drinking water
2. How relevant is the organisation of the health care system to addressing the health problems in your community?	<ul style="list-style-type: none"> • Relevant but inadequate • Organisation is adequate but resources are inadequate • Lack of mobility for outreach and for referrals • New health infrastructure projects are implemented without the involvement of the district or the community and end up with inappropriate structures built by outside contracts. • The formation of hospital management board and village development committees at PHU levels help in identifying, prioritising and finding solutions to problems • At least the basic structures are in place, even if not working effectively, not all DMOs have training in public health • Organisation of systems is relevant but the machinery to implement is not functional because of; centralisation, uneven distribution of resources, no monitoring system for drugs handling, proliferation of quacks and drug peddlers. Lack of adequate number of vehicles to carryout primary health care activities, e.g. monitoring and supervision, supply of logistics to the periphery, etc. • Some health problems are well catered for, others not, mainly due to lack of diagnostic services, i.e. facilities, equipment and trained staff. • Distance to health facilities is too far
3. To what extent do you think the health care system provides quality and appropriate services to the population?	<ul style="list-style-type: none"> • The MOHS is providing low quality services due to lack of trained personnel and logistics • Overall drug shortage, both at national and district levels • Too many patients have to be exempted • EDL does not include some drugs needed for local conditions, e.g. typhoid • Some Standard Treatment Guidelines exist but have not been updated for long time

Issue	Responses
	<ul style="list-style-type: none"> • Effective implementation of the element of primary health care • Have set up community development committee sub group on health to monitor performance of the PHUs, using EHOs as social mobilisation officers • TB/Leprosy patients are adequately cared for • Hospitals and PHUs are understaffed • Less attention is paid to environmental health • Staff leaving MOHS to join NGOs for better pay and conditions of service • All staff come late on duty • Lack of willingness of management to punish subordinates • Community participation should be increased
4. Are you satisfied with the health care system in providing appropriate services to your community?	<ul style="list-style-type: none"> • Huge gap exists between what is provided and what is required • Range of services limited by lack of trained staff and availability of basic equipment • Poor staffing, inadequate supplies, poor referral system, poor road network, centralisation of resources, existence of illicit health workers, little access to safe water for all • Health services are not accessible to the rural majority • No motivation or incentives to keep staff in remote rural areas • Infrastructure destroyed during the war not yet replaced • Lack of drugs and those available are expensive
5. To what extent are the services accessible and affordable to the population, is there a referral system?	<ul style="list-style-type: none"> • Accessibility is minimal • Utilisation is below 50% due to bad roads and transport problems, not affordable • Distances to health facilities too long. Some villages over 20 miles to the nearest PHU • Lack of transport for referral, both MOHS provided and commercial transport in some areas • People cannot afford, utilization rates have fallen dramatically • To a minimal extent services are accessible and affordable to the population. • Poor functioning of referral systems • There is a referral system in place but has so many levels of delay due to cost, ignorance and difficulties in accessing the facility. • Quack and Peppe 'doctors' access all villages, therefore they are popular
6. How should the health services be financed?	<ul style="list-style-type: none"> • Health workers feel "health should not be free" • Fully from GOSL • Current major source of funds GOSL via Ministry of Finance, but irregular, not received every quarter and not

Issue	Responses
	<p>keeping to original budget allocations.</p> <ul style="list-style-type: none"> • Community funds, donors, GOSL, MOHS and hospital funds (departments) • GOSL and Cost recovery system • Community based insurance • Experience from post-war is for the services to be funded from external resources
7. What system of payment do you propose?	<ul style="list-style-type: none"> • Free of cost provided there is a system put in place to ensure sustainability • Free of cost to all except those able to pay • Services for women during pregnancy 1/3 of cost, children ½ and elderly and destitute free (but standard definition of destitute) • ANC Le500, Children Le500, elderly and destitute free • “if all those that should be exempted are, they account for 60-70% of the population , who will be left to pay the <u>wage bill?</u>” • “people are too used to free services during the war”
8. How do you determine the quality of services provided?	<ul style="list-style-type: none"> • Staff <ul style="list-style-type: none"> ○ Critical lack of trained staff ○ Availability of trained staff - adequate trained staff correctly posted ○ MCHAs need skills updating and expansion of skills ○ Timely reception by staff; better commitment of staff to duty ○ Opening hours; duty organise in shifts ○ All most all PHUs have no support staff, e.g. cleaners, security guards. • Drugs and supplies <ul style="list-style-type: none"> ○ Overall shortage of drugs and supplies ○ Cost of some drugs not competitive with private sector ○ Appropriate and timely supply of drugs equipment and medical supplies ○ Proper handling, storing and dispensing of materials • Infrastructure and equipment <ul style="list-style-type: none"> ○ Lack of appropriate staff housing ○ Lack of appropriate structures ○ Lack of basic equipment • Accessibility and Utilisation <ul style="list-style-type: none"> ○ Accessibility; the closer the distance to the main referral point the better the services. The social and economic activities of the people and the seasonal variations on income and on the road network can impact on utilisation.

Issue	Responses
	<ul style="list-style-type: none"> ○ Services should be within the reach of the community in terms of cost ○ Services provided depends on the needs identified and prioritised by that community, mainly curative, promotive and preventive services routinely, involvement in the monthly community development committees. ○ Should have 24hrs services
<p>9. What barriers exist for the utilization of services?</p> <p>10. Why do you think women die during pregnancy and childbirth in your community?</p>	<ul style="list-style-type: none"> ● Out of pocket expenses for transport to facilities ● Accessibility; poor roads, distance of health facility from its users, natural barriers ● Poor attitude and behaviour of staff – moral conduct, level of training, lack interest in job ● Availability of appropriate staff and services; inadequate staffing, poor motivation ● Cost; high cost of services, occupation of service users, most patients cannot afford ● Minimum costs Le500 currently ● Staff are demotivated due to non-payment or late payment of salaries ● People have greater access to ‘quack doctors’ in the village and their drugs are cheaper. ● “The Woman’s world is not here!” ● Barriers start at home, men make the decisions, very often there is no money, and transporters charge more for woman in labour. ● Clinical reasons; eclampsia, anaemia, Poor ante natal care, Etc. ● Early marriage and teenage pregnancy ● Lack of trained and competent staff ● Ignorance ● Poverty, stay at home ● High illiteracy ● Late referral at all levels ● Poor road network ● Poor referral systems, poor transport and communication, delays in referral ● Poor supervision of MCHAs and TBAs by DHMT ● Mismanagement by untrained personnel ● Cultural and traditional beliefs ● Most obstetric emergencies are not detected during pregnancy ● Repeated pregnancies at short intervals ● Poor diet and malnutrition ● Disease burden factors

Issue	Responses
11. Why do you think so many children die in your community before they reach the age of five years?	<ul style="list-style-type: none"> • Big problem of malnutrition, feeding programmes commence once malnutrition diagnosed, then end once weight gains, underlying problems not been adequately addressed. • Poverty • Ignorance and traditional beliefs • Because of five killer diseases (malaria, pneumonia, measles, diarrhoea & vomiting, anaemia) • Herbal drug intoxication • Worm infestation • Harmful food hygiene practices • Poor immunisation status, low coverage, some families don't take their children for immunisation • Late referral, come late to clinic • Lack of trained personnel • Inadequate drugs • Presence of illegal medical practitioners in the communities
12. What do you propose needs to be done to prevent or reduce the high rate of deaths to women and children?	<ul style="list-style-type: none"> • Need to train women on self-reliance • Large number of TBAs untrained and unsupervised, not referring women • Government to provide accessible, acceptable and affordable health care services, to supply adequate drugs, equipment, trained staffs and health institutions. Construct good road net work. Control of illegal drug handlers, • The community must be involved at all stakes in planning, priority setting, implementation and monitoring and evaluating. To ensure a very good and timely clinic attendance through organised community development committees, maintained referral system, need to increase the literacy rate and food provision to be adequate. Need for greater community sensitization. • Need to train, maintain and retain staff, improve their skills through refresher training over time. Increase salaries and provide accommodation • Need to improve road network • Provide communications and transportation • Provide electricity • Proper monitoring and supervision • Community should promote more TBAs going forward for training • To be a committed and effective health staff • Better implementation of health activities through MOHS • To provide adequate funds for implementation of health activities.

Issue	Responses
13. In your opinion, what is the most serious health problem in your community?	<ul style="list-style-type: none"> • NGOs need to be transparent, address felt needs of the community, use the services of indigenes, collaborate/co-ordinate with line ministries, augment the work of government, and build capacity of DHMTs and PHU staff. • Donors should not dictate terms, cut down on bureaucratic procedures, and provide funds to implement health programmes. • Malaria, number one cause of morbidity. The disease re-occurs after patient gets bites from infected mosquitoes, the disease is easily acquired because of numerous mosquitoes bites due to high breeding places. • Obstetric complications • All ages are affected but children under 5 years and pregnant women are our main work load; • Malaria, pneumonia, diarrhoea and vomiting, lassa fever and typhoid fever. • 410 children died of malaria during 2003 (Kenema), 3 -5 % of all cases end in fatality • Lots of drug resistance, sub-standard drugs, under dosing, etc. • Poor WatSan causes diarrhoea and malaria, need ITNs, vector control. • Women mostly look after chronically ill, women from the family or relatives
14. How do you propose to prevent and control this most serious health problem?	<ul style="list-style-type: none"> • Greater sensitization of community on seeking health care early • Need more trained staff, especially the numbers of trained MCHAs and increase their skills • Provision of special care for under-fives and pregnant women • Provision of ITNs, community action, IEC, early diagnosis and treatment • Intensify community education and action on environmental sanitation • Improve on environmental sanitation with special regards to waste and water management • Embark on vector control, ITNs etc • Safe sex practices encouraged, sustained health education. • Provision of quality water and sanitation facilities • Improve early diagnosis and treatment, provision of prophylaxis • Encourage prompt referral of severe cases • Use Paramount Chiefs to speak to people to change behaviour, e.g. drinking water from river resulting in outbreak of diarrhoea. • Need to practice barrier nursing • Need to review the range of drugs available at PHUs to deal with common conditions
15. What do you know about HIV?	<ul style="list-style-type: none"> • Spread through unprotected penetrative sex; contaminated blood and blood products, mother to child, • Contactable by anybody regardless of age, sex and religion, everybody is at risk

Issue	Responses
	<ul style="list-style-type: none"> • Can be prevented and managed by: Abstinence, Faithfulness and correct use of condoms. Health education; use of ARVs, use of sterile instruments and correct antibiotics are used for STIs • HIV/STIs very big problem in our community. • Need to treat partners for STIs • People don't think HIV is real. • Lack of laboratory facilities to confirm HIV status of patients • Need access to ARVs • Need to address issue of stigma • Poor availability of condoms
16. What do you think is responsible for the health problems in your community?	<ul style="list-style-type: none"> • Poverty is the main cause of health problems in our community • Poor food hygiene practices • Poor environmental sanitation
17. What do you understand by poverty?	<ul style="list-style-type: none"> • Poverty is a condition where one cannot adequately meet his or her basic needs • To be deprived of democracy, employment, education, good health services • Poverty is the lack of rights for certain sectors of the population to take part in running of the country
18. Do you think there is poverty in this part of the country?	<ul style="list-style-type: none"> • "We are the poorest of the poor". • Yes, majority of people cannot afford a meal a day • Devastation of homes and facilities during war • Heavy dependency on government for everything
19. What are the causes of poverty?	<ul style="list-style-type: none"> • Unemployment • Ignorance • Corruption • Bad governance • Laziness • Heavy disease burden, especially malaria • Family commitment, including extended family • Illiteracy, often leading to poor economic management • Destruction of lives and properties during the war, adverse effect of war • Single parents • Polygamy

Issue	Responses
	<ul style="list-style-type: none"> • Poor planning and management at domestic and national level • Lack of birth control, high birth rate • Poor infrastructural development • No credit facilities • Lack of opportunities • Desecration of lands • Misappropriation of public funds and lack of accountability • Poor management of resources • External and internal debt • Too much dependency on imported goods
20. What do you propose needs to be done to prevent or reduce poverty in your part of the country?	<ul style="list-style-type: none"> • Education should be free and compulsory • Corruption should be minimised • Establish formidable agricultural sector and provide employment facilities, Extensive farming though communal work • Government to provide jobs, free education, free sporting activities • Need improved infrastructure, electricity, roads, water supply, etc • More job opportunities created • More support for income generating activities • Community needs to organise themselves better in skills training • Individuals need to be patriotic • Need to discourage polygamy and encourage monogamy • More funding required from donors and assistance from NGOs • NGOs to be more transparent • Donors should have minimum bureaucracy
21. What do you think is the right number of children for a, b, c.	<p>a. Woman – 5, 4, 3, 2, 1 b. A man – 10, 8, 6, 5, 4, 3, 2 c. A married couple – 4, 3</p>
22. What do you think needs to be done to achieve or to maintain the desired number of children?	<ul style="list-style-type: none"> • Good housing, education, medical care and proper nutrition and clothing • Family planning with adequate agreement between the two couples • Implement/sensitization of reproductive health services at all levels • Avoidance of early marriages

Issue	Responses
	<ul style="list-style-type: none"> • Space children using family planning services • Education of the girl child • “Severe punishment for pregnant unmarried school girls!”
23. Do you think there should be a law to regulate the minimum age of marriage for Women and Men	<ul style="list-style-type: none"> • Yes
24. What do you propose to be the minimum age of marriage;	<p>a) Women - 21 years, 18 years, 19 years, 25 years, 22 years</p> <p>b) Men - 25 years, 21 years, 20 years, 27 years, 30 years, 23 years (“30 years to enable men to complete college and have gainful employment”)</p>
25. What do you think needs to be done to achieve and maintain good environmental sanitation by: Individual families, the community, Government and Organized groups?	<p>a. Delegate duties relating to daily cleanliness of the home to Father, Mother and Children, to clean and maintain clean compound always, proper disposal of home generated waste, compost heap or pit, plate racks, clothes lines, etc</p> <p>b. Collective communal work participation, enlist communities’ participation in environmental health programmes, safe water, VIPs, provide local tools for environmental activities.</p> <p>c. Embark on monthly cleaning, provide tools and equipment from the MOHS, improve on appropriate refuse disposal system, government should provide basic logistics, institute policies, training of staff. Government should enforce public health policy</p> <p>d. workplan, laws made and enforced, provision of logistics, youth participation, need more collaborate/co-ordinate with government and communities in environmental sanitation activities/programmes, community should be encouraged to volunteer</p> <p>- Should be doing more environmental education through the school health programme.</p>
26. What is your opinion about the decision and steps Government is taking to decentralise the health care delivery system?	<ul style="list-style-type: none"> • Very positive, but no community consultation. • It is a good idea, provided it is properly implemented and supported • Good, less travelling from one end of the country to the other • A good decision and a step forward • Let decentralisation come with the funding • Give districts responsibility to run own affairs • Going to give health services to Local Government, what does that mean? • Good if done properly has the potential to reach the grass roots.
27. What aspects of the health services do you want to see improved?	<ul style="list-style-type: none"> • 2More funding, 500% increase!” • Water and Sanitation • Health promotion

Issue	Responses
	<ul style="list-style-type: none"> • Referral system • Hospital care • More trained, qualified and motivated health workers • EPI • Surgical services • Reproductive Health • Ophthalmology
28. What is the single most important thing you would propose to do to improve health?	<ul style="list-style-type: none"> • Easy access • Good nutrition • Behavioural change • Health Education, Prompt action to access health care once ill • Cleanliness • Implementation of primary health care • Improved water sources • Regular supply of quality affordable drugs • Improved building structures and basic equipment, including staff accommodation • Income generation • Improve provision of health staff and their conditions of service • Improve transport both for logistics and referral • “kill all mosquitoes” • People need to do some manual labour

Annex 3: List of Persons Consulted

Ministry of Health and Sanitation

Mrs. Agnes Taylor-Lewis	Hon. Minister of Health and Sanitation
Dr. Noah Conteh	Director General Medical Services
Dr. Clifford Kamara	Director Planning and Information
Dr A Williams	Director Hospital and Laboratory Services
Dr B Kargbo	Health Sector co-ordinator, National AIDS Secretariat
Dr P Roberts	Director Primary Health Care
Mr M Sandi	Director Finance and Resources
Mr B.S. Turay	Director Drugs and Medical Supplies
Dr. A.A. Sandi	Deputy Director Human Resources
Dr KS Daoh	Programme Manager, Reproductive Health
Dr ML Bayyoh	Consultant Surgeon and Hospital Care Manager
Dr. F. Dafoe	Programme Manager, TB and Leprosy
Dr. S. Kamara	Programme Manager, Malaria
Dr AL Seisay	Director Disease Prevention and Control
Ms S Scott	Programme Manager, Nutrition
Mr Michael Amara	Health Economist
Mr Y Conteh	Donor/NGO Liaison Officer
Mr John Tommy	Senior Sanitary Engineer
Dr MK Gborie	Programme Manager, MCH/EPI
Dr P Capdegelle	Team Leader, HSSP
Mr Soyape Lungu	Human Resource Adviser, HSSP
Mr Karl-Eric Lindberg	Health Financing and Management Adviser, HSSP
Dr D Kone-Bamba	Drugs Procurement Adviser, HSSP
Mrs M John	Acting Director Nursing Services
Mr V Milton	Architectural Services Unit

District Consultations

Bo DHMT
 Bombali DHMT
 Bonthe DHMT
 Kailahun DHMT
 Kambia DHMT
 Kenema DHMT
 Koinadugu DHMT
 Kono DHMT
 Moyamba DHMT
 Port Loko DHMT
 Pujehun DHMT
 Tonkolili DHMT
 Western Area DHMT

The district consultations included meetings held with all District Health Management Teams, District Hospital staff, NGOs working in the area, Church Hospital providers, local leaders, including Paramount Chiefs, local Members of Parliament, and health facility users. Visits were made to at least one Primary Health Unit in each district and discussions were held with the staff and patients present.

Development Partners

Dr Kedrick Kiawoin	Health Coordinator, UNICEF
Dr Abu Pratt	Project Officer, UNICEF
Mr James Sackey	Country Representative, World Bank
Dr M Miatudila	Senior Public Health Specialist, World Bank, US

Mr E Ofori-Anyinam	Architect, External Consultant World Bank
Ms Karine Genty	Programme Officer, European Union
Dr Rosanna Magoga	Acting Country Director and Health Co-ordinator, MSF-Belgium
Mr Joseph Senesie	Health Co-ordinator, World Vision
Mrs Marion Morgan	Executive Director, CHASL
Ms Jennebu Mahonde	Health Co-ordinator, GTZ
Ms Haja Kultumi Karim	GTZ
Ms Michelle Mancini	Health Officer, CRS
Dr J Saweka	Country Representative, WHO
Mr AT Renner	Health Economic Adviser, WHO
Dr Femi	Acting Health Coordinator, Merlin
Ms Emma Morley	Social Development Adviser, DFID
Mr Keith Bastin	Senior Governance Adviser, DFID
Mrs MA Diarra	Assistant Representative, UNFPA
Dr PS Sinkana	Consultant, UNFPA
Mr J Davidson	National Director, Christian Children's Fund
Mr M Sesay	Health Coordinator, Christian Children's Fund
Other	
Mr Eddie A Conell	Director, Vinell Nursing Home (Private)
Dr I Palmer	Acting Medical Officer in Charge, Blue Shield Trust, Curney Barnes Hospital (Private)
Mr Joel Cutting	Consultant Decentralisation Adviser, DFID
Mr G.P. Greenwell	Technical Adviser, US Census Bureau

Annex 4: List of Documents Consulted.

Beyond survival: A study of children in difficult situations in Sierra Leone, Plan, Sierra Leone, 2003.

Commonwealth Secretariat, Women and men in partnership for post-conflict reconstruction, Report of the Sierra Leone National Consultation, Freetown, Sierra Leone, 21 -24 May, 2001: 2002.

Evaluation of Safe Motherhood services in Sierra Leone, UNICEF 2003.

Government of Sierra Leone, Institutional Reform and Capacity Building Project (IRCBP), Environmental and Social Management Framework, Final Report January 2004.

Government of Sierra Leone, Health Sector Reconstruction and Development Project, Project Document, World Bank, February 2003.

Government of Sierra Leone, National policy on the advancement of women, 2001.

Government of Sierra Leone, National HIV/AIDS Policy, January 2002

Government of Sierra Leone, National policy on gender mainstreaming, 2001

Government of Sierra Leone, Survey Report on the Status of Women and Children in Sierra Leone at the end of the Decade, Central Statistics Office, Ministry of Development and Economic Planning, November 2000.

Health, Nutrition and Population Technical Notes, World Bank PRSP Source Book, www.worldbank.org , continuously updated.

Joint Staff Assessment and the Interim Poverty Reduction Strategy Paper, IMF and IDA, July 2001.

Malawi Poverty Reduction Strategy Paper, Government of Malawi, 2002

Medium Term Expenditure Frameworks (MTEFs), An Introduction, DFID Health Systems Resource Centre, 2002.

National Recovery Strategy, Sierra Leone 2002-2003

Final Report, National Sensitization and Capacity Building Workshops on the PRSP May 23 to August 16, 2003, Network Move ment for Justice and Development, August 2003.

Participatory Poverty Assessment (PPA) Report, PASCO 2003

Participatory Poverty Assessment (PPA) Report, PASCO 2004 (Early Draft)

Project Appraisal Document, Republic of Sierra Leone, HIV/AIDS Response Project, The World Bank, February 2001.

Report of the Public Expenditure Tracking Survey (PETS), Volume One-Main Report, July-December 2001, Ministry of Finance, December 2002.

Republic of Sierra Leone, Ministry of Health and Sanitation, National Health Policy, October 2002 (draft)

Sierra Leone National Drug Policy, MOHS, June 1993

Sierra Leone National HIV/AIDS Programme, Monitoring and Evaluation Manual, Volume One, Indicators, National AIDS Secretariat, December 2003.

Sierra Leone National HIV/AIDS Programme, Monitoring and Evaluation Manual, Volume Two, Indicator Dictionary, National AIDS Secretariat, December 2003.

Status Report, Preparatory Activities for the Full PRSP for Sierra Leone, PASCO, May 2003.

Status Report, Preparatory Activities for the Full PRSP for Sierra Leone, PASCO, November 2003.

The Bamako Initiative in Sierra Leone, Operational Guidelines, MOHS, May 1997.

The design and evaluation of maternal mortality programmes, Centre for Population and Family Health, School of Public Health, Columbia University, 1997.

The Medium Term Expenditure Framework Guidelines, Ministry of Finance, Republic of Sierra Leone, August 2003.

Update on the preparation of the PRSP, Ministry of Health and Sanitation, Government of Sierra Leone, October 2003.

Annex 5: Proposed Measures/Actions to address underlying issues in Nutrition

Underlying Issue	Objective	Policy Measure/Action	
1. 27.2 % of U5 are under weight, 33.9% stunted, 9.8% wasted 2. The high LBW (53%) indicating serious problem with maternal nutrition	To strengthen nutrition education activities	Introduce nutrition education in school curriculum at all levels to both boys and girls	
		Develop uniform nutrition education materials and messages Provide nutrition education in all U5 and ANC Incorporate nutrition education into adult education and non-formal education	
		Link nutrition education to income generating activities for women	
		Do nutrition education over radio and television	
	Establish functional therapeutic feeding centers in all government hospitals Establish a National and Regional surveillance system for monitoring the foods supply and nutrition situation		Provide space in all district hospitals for therapeutic feeding
			Train district hospital staff on management of severe malnutrition
			Provide food for therapeutic feeding in hospitals and materials for nutrition education Conduct a National Nutrition Survey every five years
			Screen all U5 for malnutrition routinely in all PHUs and compile monthly summary
			Collect LBW data routinely in districts and submit monthly reports
			Train staff on screening for malnutrition Disseminate all nutrition information to all partners in the district
Early introduction of non-breast milk food and water to infants and consequently low prevalence of exclusive breastfeeding- less than 2% in the country	Encourage more breastfeeding in urban and rural area Promote breastfeeding and proper weaning practices with appropriate local weaning foods	Promote and support exclusive breastfeeding up to 6 months	
		Study the KAP of mothers to child feeding Encourage the community to grow and utilize local foods to prepare complementary foods	
		Pregnant women should be offered HIV testing and counselling	
		Breast milk substitutes should not be promoted in hospitals and government institutions	
		Ban advertisement of breast milk substitutes in the mass media	
		Reject all donations of breast milk substitutes even in emergencies	
3. High prevalence of iron deficiency anaemia	Reduce prevalence of iron deficiency anaemia among pregnant women and children by one third by 2010	Provide iron and folic acid to all pregnant women and children U5 in all health facilities throughout the country	
		Treat all pregnant women and lactating women up to 6 months after delivery for malaria and worms, and provide malaria prophylaxis for them.	
4. High prevalence of iodine deficiency	To eliminate iodine deficiency disorders by 2010 through salt iodation	All salt used for cooking and animals consumption should be iodized	
		Ban the importation of non-iodized salt	

disorders		Stress the importance of iodized salt in nutrition education talks in clinics and the mass media
5. Possible Vitamin A deficiency	To virtually eliminate Vitamin A deficiency and all its consequences by 2010	Provide Vitamin A supplementation to all children 6-59 months twice yearly
		Stress the importance of Vitamin A and iron rich foods in nutrition education talks
		Place emphasis on the treatment of infections and diarrhoea
		Provide potable water supply for rural and urban dwellers to prevent water-borne diseases
		Provide adequate sanitation facilities for both rural and urban households to prevent infections
6. Inadequate number of appropriately trained personnel in the food and nutrition sector	To achieve appropriate capacities in food and nutrition sector	Train relevant staff in Food and Nutrition technology

Source: National Action Plan for Nutrition and Food Security, 2001