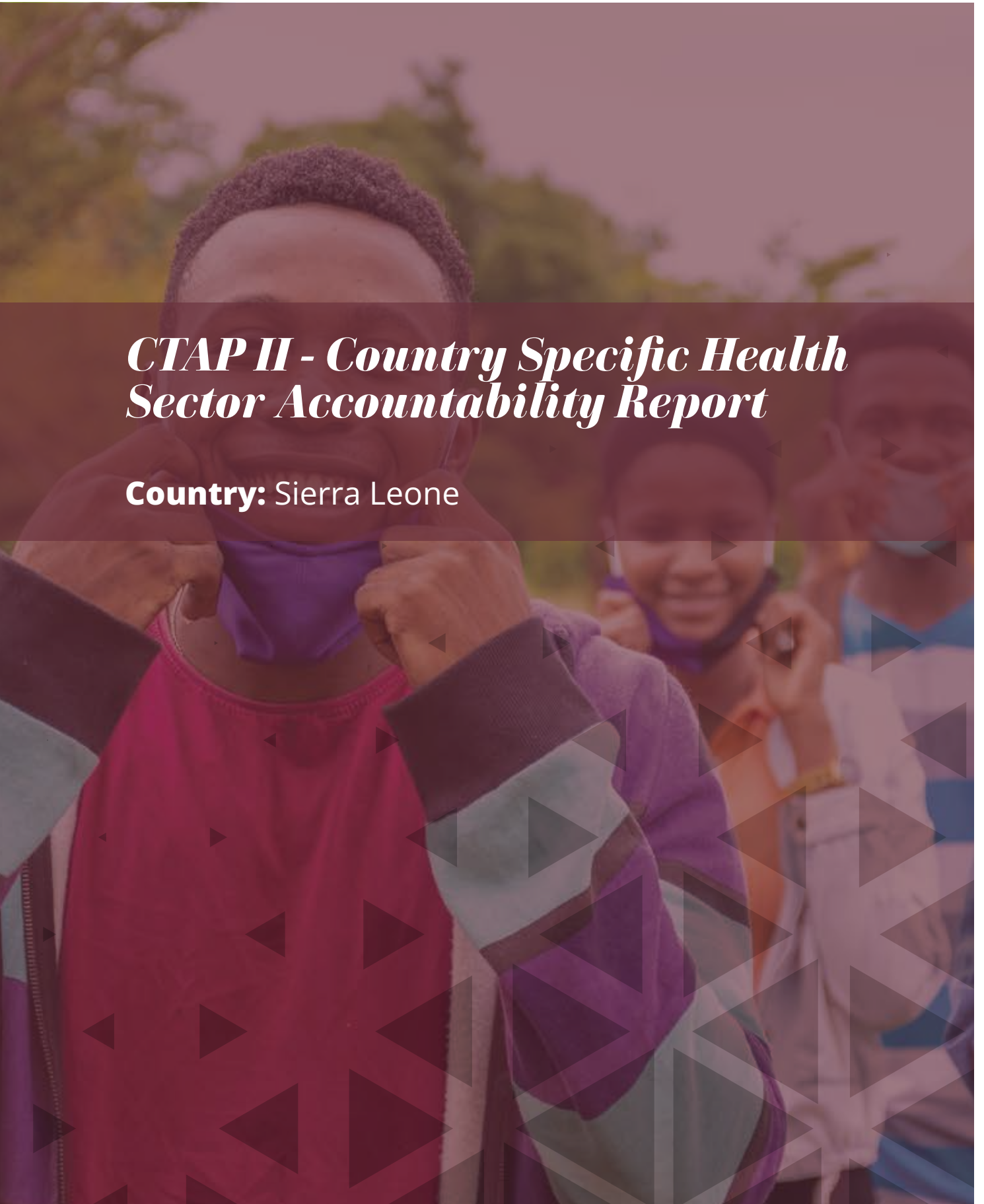




CTAP II - Country Specific Health Sector Accountability Report

Country: Sierra Leone



Disclaimer

This document has been produced by BudgIT to provide information on budgets and public data issues. BudgIT hereby certifies that all the views expressed in this document accurately reflect our analytical views that we believe are reliable and fact-based. Whilst reasonable care has been taken in preparing this document, no responsibility or liability is accepted for errors or for any views expressed herein by BudgIT for actions taken as a result of information provided in this Report.

Contents

TABLE OF CONTENTS	ii
TABLES AND FIGURES	iii
ACRONYMS AND ABBREVIATIONS	iv
EXECUTIVE SUMMARY	01
BACKGROUND RESEARCH METHODOLOGY	04
Section Two: Health Sector Governance	09
Section Three: Political Economy of Health Sector	13
Section Four: Law and Legislative oversight on Health Care	16
Section Five: Health Care Policy, Funding and gaps	20
Section Six: Citizen Data and Voices on Health Access and Accountability	26
Section Seven: Conclusion and Route to Reform	33
APPENDIX	36
REFERENCES	40

Tables and Figures

- Figure 1:** Gender Respondent
- Figure 2:** Age bracket of respondent
- Figure 3:** Which type of health facility do you frequently visit
- Figure 4:** Did you receive good medical care during your visit
- Figure 5:** Did the health care worker as doctors or nurses treat you right during your visit
- Figure 6:** Was the health facility equipped with adequate drugs and equipment to respond to the individual care reported
- Figure 7:** Which category of patients did you belong to at the time of visit
- Figure 8:** Did you pay money for the services rendered to you
- Figure 9:** Is there a dedicated team of senior officers with the sole responsibility to monitor the work of the health facility
- Figure 10:** Do you know how funds for your health facility come and are spent
- Figure 11:** Have you been given COVID 19 vaccine
- Figure 12:** Are you aware of funds provided for the fight against COVID 19 in your district, chiefdom or town
- Figure 13:** Are ordinary citizens in your district, chiefdom or locality taking part in decisions regarding health care
- Figure 14:** Services paid for in the health facility

Acronyms and Abbreviations

CBO:	Community Base Organization
CHCs:	Community Health Centres
CHPs:	Community Health Posts
COVID-19:	Corona Virus
DHMT:	District Health Management Team
DMOs:	District Medical Officer
FHC:	Free Health Care
HRMO:	Human Resource Management Office
INGOs:	International Non-Governmental Organizations
IPC:	Infections Preventions and Control
IRC:	International Rescue Committee
MCHPs:	Maternal and Child Health Posts
MDAs:	Ministry Department and Agencies
M&E:	Monitoring and Evaluation
MoF:	Ministry of Finance
MoHS:	Ministry of Health and Sanitation
MS:	Medical Superintend
MSF:	Medecins Sans Frontires
NHA:	National Health Account
NaCOVERC:	The National COVID-19 Emergency Response Centre
NMSA:	National Medical Supply Agency
NGO:	Non- Governmental Organization
PHC:	Primary Health Care
PHUs:	Peripheral Health Units
POCH:	Parliamentary Oversight Committee on Health
UKAid:	United Kingdom Aid
UNICEF:	United Nations Children Emergency Fund
WHO:	World Health Organization

Executive Summary

Executive Summary

The current findings suggest that significant progress has been made in the health sector governance space. The multi-stakeholder approach in every tier of the health administration and policy formulation has been clearly given a boost to the sector. This was largely evident in the aspect of the devolution of responsibilities and the inclusion of local government authorities in the administration of primary healthcare at district and ward levels. The findings also identified that the additional budgetary support from the central government to the health sector, coupled with the inadequate Parliamentary Oversight on Health, raised the funding challenges and aided requisite policy formulation and development towards the sector. Additionally, the involvement of the HRMO in the promotions, recruitments, and transfers of healthcare workers was to largely reduce the unfair advantage in the sector and enhance the overbearing human resource challenges and the undue delay in the approval of volunteer nurses. But this still remains a challenge.

The survey findings revealed that irrespective of the additional budgetary allocation, policy reforms, and system reviews, the introduction of the FHC programme to improve the access and confidence of both the health care workers and the end users has not been impressive. The respondents gave glaring feedback about these efforts. Some recounted that they prefer charges be levied for the services received in the hospital as the non-availability and shortages of essential drugs and medical supplies are becoming a daily occurrence. The survey indicates that the sector falls short in designing attractive retention packages for specialist doctors and midwives who are being attracted by other lucrative employers. It appears most of the doctors and nurses who are willing to work are either students or have other engagements. The rate of corruption and misappropriation of health supplies is alarming,

with a glaring need for reform. As expected, the administration, policy formulation, oversight, and procurement of medical supplies is done using a multi-sectorial approach to ensure the desired outcome for the benefit of both the health care workers and the end users. The research identified that though the health sector leverages the expertise of the Ministry of Health and Sanitation (MoHS),^{1,2,3,4,5} Parliamentary Oversight Committee on Health (POCH) and National Medical Supply Agency (NMSA) to the key objective of the master plan, it has yet to yield fruition. The research revealed that the availability of medical supplies throughout the year is still a challenge the sector is battling with. The survey reports suggest that the funding gap remains largely a challenge the sector is yet to overcome. Though the central government is committed and has increased the MoHS's budgetary allocation by a significant amount, timely disbursement of the required funding appears to be an issue.

The survey revealed that the sector also received support from donor partners for other activities undertaken during their operations. Conversely, the support from the central government is required to support the day-to-day administration of the hospitals. The delay in the disbursement of these needed resources adversely affects the smooth administration of the health sector. The survey reports suggest that the access and accountability of health care facilities in the country are frequently visited by women. **Of the 232 respondents under citizen's voices and data randomly sampled during the survey, 175 of them were females, which accounted for about 75.4% of the respondents. The remaining 24 were males and accounted for about 24.6% of the respondents.** This data clearly shows that females visited hospitals at a higher rate than males. Of this data, about 101 of them are between the ages of 18 and 30 years old, which 4 accounts for about 43.5% of those who visited

1. Ministry of Health and Sanitation Sierra Leone. Directorate of Planning, Policy & Information (DPPI). Sierra Leone Health PER DPPI Input (Draft). April 2020.
2. Ministry of Health and Sanitation Sierra Leone. 2017. Sierra Leone National Reproductive, Maternal, New-born Child and Adolescent Health Strategy 2017–2021. Freetown.
3. Ministry of Health and Sanitation Sierra Leone. 2021 (draft). Sierra Leone National Health Sector Strategic Plan 2021–2025. Freetown.
4. Ministry of Health and Sanitation Sierra Leone. 2018. Summary Report of the 2017 SARA Plus in Sierra Leone: Service Availability and Readiness Assessment (SARA), Quality of Care Survey, and Data Quality Review.
5. Ministry of Health and Sanitation Sierra Leone. 2015. Sierra Leone Basic package of Essential Services, 2015–2020. Freetown.

the hospitals at a youthful age. Interestingly, about 214 of the respondents, which represents about 92.6%, indicate that they access government medical facilities. While approximately 13, representing approximately 5.6% of the respondents, indicate that they visited private institutions. From the data, it appears that the reliance on government hospitals is the first choice and private hospitals are alternatives. The survey exposed the knowledge gap among respondents with respect to who principally funds the government facilities in their locality.

Of the 231 respondents, about 170, representing 73%, indicated that they did not know who funded their health facility in the country. On the flipside, about 61 of the respondents, which represents about 26.4%, responded in the affirmative. Similarly, about 147 of the 232 respondents sampled, which represents about

63.4%, indicated that they were not aware of funds provided for their local hospitals or the District Health Management Team (DHMT) in their districts for the fight against COVID-19.

The secrecy surrounding the financing of public institutions is a cause for concern.

However, of the 232 respondents sampled, 168, representing 72.4%, indicated that they have received the COVID-19 vaccine, while 64 respondents, representing 27.6%, indicated that they have not received it. The data shows that though the respondents are not aware of the funding source for the combating of COVID-19 in their locality, the roll out of the vaccine has made significant inroads in the fight against the pandemic. Finally, the survey reports catalogued the plausible workable solutions made by respondents on what the health sector can, moving forward, embark on to ameliorate the current status quo.



Background and Methodology

Background and Methodology

Sierra Leone has some of the world's worst health indices, with a life expectancy of 47 years, an infant mortality rate of 89 per 1,000 live births, an under-five death rate of 140 per 1,000 live births, and an infant mortality ratio of 857 per 100,000 births (SLDHS, 2008). Most illnesses and deaths in Sierra Leone are preventable, with dietary deficiencies, pneumonia, anaemia, malaria, TB, and now HIV/AIDS being the leading causes of death. Diarrhoea and acute respiratory infections are also major causes of hospitalization and illness in the country. The rural population and ladies within the rural population bear the largest burden of disease. Women are also more likely than men to be forced to curtail their economic activity due to illness. Sierra Leone's healthcare expenses remain relatively high, resulting in low usage (on average 0.5 visits per person per year). Out-of-pocket expenses of over 70% remain among the highest in Africa (NHA Report, 2007).

According to a survey commissioned by the Ministry of Health in 2007, even minor charges tended to prohibit more than half of the population from accessing health care, and present exemption methods do not appear to operate (Health Financing Assessment, Oxford Policy Management 2008). Based on a review of 50 developing nations, the Health Financing Group (Abuja Declaration, 2005) proposes that the government increase its per capita health expenditure to 15% of total public expenditure to reverse its declining per capita health expenditure.

The implementation of free health care in all peripheral health facilities and district hospitals was advocated as a realistic policy solution for addressing the poor majority's health.

Furthermore, investment in increasing service quality is vital. The inadequate public investment in the sector is largely to blame for the health system's poor and dysfunctional state. According to WHO, per capita government health expenditure in 2015 was US\$14, compared to

US\$25 in Guinea and US\$16 in Liberia. Government spending on health as a percentage

Within a 5-mile radius, at least 25% of the population does not have access to a health facility. The few health facilities that exist are ill-equipped, lack necessary pharmaceuticals and medical supplies, and frequently lack sufficient health staff.

of total spending has never met the Abuja Declaration's 15% benchmark. It was 11.4 per cent in 2015 and even less than 10% in 2016. (SLPP Manifesto 2018). In 2018, there were 1,190 health facilities and fewer than 200 physicians serving the 7 million population. The numbers above show that the 2010 Free Health Care initiative did not have the expected impact.

There are still reports of medicine distribution leaks, a lack of manpower to deliver health care, and a lack of incentives for the small staff. Despite the Post-Ebola Recovery Strategy's efforts to improve health, the situation remains dire. The health sector is nevertheless hampered by little public investment and late disbursement, a depleted human resource base, deficiencies in disease prevention, control, and surveillance, poor service delivery, and bad governance.

Within a 5-mile radius, at least 25% of the population does not have access to a health facility. The few health facilities that exist are ill-equipped, lack necessary pharmaceuticals and medical supplies, and frequently lack sufficient

health staff. The distribution of trained and certified health workers is skewed in favour of the capital city, Freetown. Because of the bad working circumstances, trained health personnel are not kept in clinics. Many go for work in the private sector or travel abroad in search of greener pastures. In hospitals and clinics, laboratory and diagnostics facilities such as scanning and dialysis machines are quite limited. A large sum is spent on the treatment of governmental officials abroad. Other issues in the health sector include financing health care services and drug procurement and distribution.

The emphasis of the new government, which has been in office for four years, has been to increase fair and efficient access of the population (especially mothers, children, and the elderly) to quality health services.

The emphasis has been on the following topics:

- (i) health governance;
- (ii) health financing;
- (iii) human resources;
- (iv) free health care;
- (v) disease prevention and control; and
- (vi) service delivery.

Research Study

There have been significant efforts made in the last four years to introduce some policy changes with increased budgetary allocation to boost health care financing, albeit with attendant challenges such as tackling corruption within the health sector and making the small West African country healthily viable to be able to provide basic health care needs for the population with a large percentage under the age of 35.

The specific objectives of the research include:

- 1 Health sector Governance
- 2 Political Economy of the Healthcare Sector
- 3 Laws and Legislative Oversight on Healthcare
- 4 Healthcare Policy, Funding and Gaps
- 5 Citizen Data and Voices on Healthcare Access and Accountability
- 6 Route to Reform

The study looked at the dynamics of health sector accountability in Sierra Leone from the perspectives of policy and reforms, political economy, management, corruption, legislative oversight, procurement, accountability, finance and expenditure, and citizen participation and access.

Both qualitative and quantitative data gathering and analysis methodologies were used in this study. All data collection in Sierra Leone was primarily focused on health sector governance and accountability⁶.

The qualitative data was collected using descriptive studies, which included talking to people, including face-to-face interviews, focus group discussions, and paper desk evaluations. Academic papers, periodicals, textbooks, and other materials will be used. This strategy was used to assist the researcher in gathering a higher proportion of outside validity. That is the extent to which the findings can be generalized to stakeholders in the health industry. A questionnaire was created and distributed to the target groups for the quantitative investigation. The qualitative and quantitative data collected during the research procedure were analyzed. The first section covered the fieldwork and data gathered on the governance and accountability dynamics in the health sector. This section highlighted the data collected from direct interviews with the focus study group and documentation obtained from stakeholders.

The quantitative data analysis was regarded as the second and last stage of the investigation. The data collected from the surveys was entered and evaluated quantitatively using graphs, tables, and charts.

The study's scope was to explore the Sierra Leone health system and reforms over the last two years in five regions and ten districts. This study was organized as follows: acknowledgement, Executive Summary, introduction and background to the investigation, research methodology, findings and data analysis. Finally, the work included the research conclusions and recommendations, as well as an appendix.

6. Focus Group Discussions with Primary Health Care Givers 26th March -9th April 2022

Research Questions

- 1 Who are responsible terms of managing public healthcare at primary healthcare, secondary health care, and tertiary health care levels?
- 2 Who is responsible in terms of funding public healthcare: primary healthcare, secondary healthcare, and tertiary healthcare?
- 3 Who is responsible in terms of developing policies for public healthcare at primary health care, secondary healthcare, and tertiary health care levels?
- 4 How are health sector human resources managed? How is recruitment, training, promotion, transfers, monitoring, and appraisal done for healthcare personnel?
- 5 Is there any health insurance for health care workers and the populace? How does it work?
- 6 What are the roles of stakeholders in the health sector (e.g., medical professionals, populations, CBOs, MDAs, intergovernmental entities, etc.)? What are their distinct features, overlapping relationships, and other emerging issues, such as their impact on building a resilient health system? Who is responsible for managing the policy and funding of COVID-19?
- 7 What are the general healthcare performance and metrics in the district/chiefdom/health facility, including dynamics of life expectancy, child and maternal mortality etc.?
- 8 What are the recent reforms to the health sector in the areas of policy, funding, human resources, etc.? What are the political barriers to reform? What are the bureaucratic barriers to reform? Was everyone able to access COVID-19 care, including vaccines? If not, why not?
- 9 What is the nature and extent of corruption in the health sector? (This is to

provide insight into the interaction between spaces, coalitions, and platforms for progress (technical, government, and operational) and those that may hamper or prevent it).

- 10 Is there any legislative oversight of the health sector? How is it done?
- 11 How do procurement processes take place in the health sector at both national and subnational levels? Who provides oversight for COVID-19 funds, drugs, and vaccines? Our interests include legislative responsibility and oversight and procurement practices in the delivery of quality healthcare in the country.
- 12 How does the money come in and how is it spent? What is it spent on? Which area is the focus area and which area is less focused in terms of spending?
- 13 Do you receive private sector donations and financing? How is it spent? Do you receive donor and development partners' interventions in terms of spending? How is the money utilized? Does the spending of money involve citizen participation? How do you account for the money? How is monitoring and evaluation of healthcare spending done? What are the challenges of funding health care at the district/chiefdom and community levels? How were COVID-19 funds utilized? Who was in charge of COVID-19 funds?

Methodology

The survey report summarizes the important highlights of Sierra Leone's Health Governance Transparency and Accountability. The data was collected between March 28th and April 6th, 2022. The research technique included both qualitative and quantitative data collecting and analysis methodologies. The data collection in Sierra Leone was primarily focused on health sector governance and accountability. In terms of qualitative data

7. Interviews with District Health Management Teams: Kailahun, Kenema, Kono, Bo, Port Loko, Bombali, Karene, Moyamba, Western Area 26th March - 9th April 2022

collecting, anthropological field techniques were used to improve the survey's descriptive refinement. One-on-one contact with health sector personnel and users, face-to-face interviews, focus group talks, and paper desk evaluations are some examples.

Additionally, academic papers, periodicals, textbooks, and other materials were used. These techniques were used to improve the quality of the research findings and to validate the scope and proportion covered. To meet the quantitative research, questionnaires were produced in both hard copy and electronically to cover a wide range of targeted populations.

Study limitation

The research was carried out in five regional headquarters towns that also served as district headquarters towns: Portloko, Makeni, Freetown, Bo, and Kenema, as well as five other districts: Karene, Pujehun, Moyamba, Kono, and Kailahun⁷, represent ten of the sixteen districts. While the study evaluated data extending back 10 years or more, the focus was on the situation in the recent two years.

Approximately 53 health care employees and managers were targeted for face-to-face engagement and interviews on all sections of the research, while 231 people were involved in citizen perceptions of health care delivery.

SECTION 2:

Health Sector Governance



SECTION 2:

Health Sector Governance

Sierra Leone has some of the world's worst health indices, with a life expectancy of 47 years, an infant mortality rate of 89 per 1,000 live births, an under-five death rate of 140 per 1,000 live births, and an infant mortality ratio of 857 per 100,000 births⁸ Sierra Leone has a long history of the high mother and newborn mortality. The majority of maternal deaths are the result of late referrals or death on arrival. And it is largely recorded in rural areas, where it is not normally reported. Poverty and steep terrain make it difficult to transport pregnant women, breastfeeding mothers, and children under the age of five to the hospital. Death on arrival has been the most common cause of maternal and newborn mortality at the leading referral hospitals.

Today's health status in Sierra Leone is appalling.⁹ This was vividly demonstrated by how quickly COVID-19 spread over the country in less than two months in 2020, affecting over 7,667 people and causing over 125 deaths. Sierra Leone's health-care delivery system is pluralistic.

Health services are provided in the country by the government, the business sector, local and foreign NGOs, and FBOs. There are four types of medical practices: public, private for-profit, private non-profit, and traditional. Primary, secondary, and tertiary health care is provided.

Primary health units (PHUs) are the initial line of health care and are categorised into three (3) levels: Maternal and Child Health Posts (MCHPs) are located in villages with populations less than 5,000; Community Health Posts (CHPs) are located in small towns with populations between 5,000 and 10,000, and Community Health Centres (CHCs) are located at the chiefdom level and typically serve populations ranging from 10,000 to 20,000. For effective and efficient service delivery, the Government Hospital Boards Act of 2003 and the Local Government Act of 2004 devolved some government powers to local councils. To execute district health programs, local councils now collaborate with the District Health Management Team (DHMT). District and

nongovernmental hospitals provide secondary health care. Tertiary health care is provided at the regional level as well as at a few nongovernmental facilities.

According to the survey results, the administration of the country's public health care system is classified by structure for effective monitoring and oversight. The primary health care network is mostly managed by a network of Peripheral Health Units (PHUs), with oversight provided by District Medical Officers (DMOs). The Medical Superintendent oversees secondary health care, which mostly works with referral hospitals (MS). The District Medical Officer (DMO) is in charge of all medical facilities and doctors in the District and is assisted by District Health Sisters 1 and 2. The DMO and the District Health Management Team (DHMT) are solely in charge of overseeing the District's primary, secondary, and tertiary health care. They develop policies for the proper management of the District's Health Sector.

***...COVID19 spread
over the country in
less than two
months in 2020,
affecting over 7,667
people and causing
over 125 deaths.
Sierra Leone's
health-care delivery
system is pluralistic.***

8. Sierra Leone Demographic Health Survey, 2008
9. SLPP Manifesto 2018

According to the data, the health sector has likewise been largely decentralised. At various levels, the central government and local councils have primacy, administering and overseeing duty. The respondents agreed that the Ministry of Health and Sanitation (MoHS) is primarily responsible for funding public health in the country. However, respondents stated that INGOs receive complementary assistance.

Around 170 respondents, or 72 per cent, said that the development of policies for health sector management is done by local councils and the federal government through the (MoHS).

According to the survey, significant progress has been made in the Human Resource Management of health care workers in terms of promotions, transfers, and appraisals through the Human Resource Management Office (HRMO), with recommendations from the Council, the DMO's office, and the Medical Superintendent (MS), as appropriate. **The country, however, has yet to enact a Health Sector Insurance Policy for citizens and workers. Although development is underway, it has not yet been fully implemented.** However, recruitment is meant to be done through District Human Resources officials.

Ideally, nurses who graduate from nursing school should collect the Public Service Commission Form, fill it out, and submit it to the Human Resources department, which should forward it to the newly formed Health Service Commission for processing before presenting it to the Nurses Board for vetting before final recruitment. Unfortunately, according to anonymous sources, some recruited workers into various health facilities bypass the District Human Resources, move directly to Freetown, and wangle their way into employment.

Others must pay between one and three million Leones in addition to various non-monetary incentives. This is due to a large number of volunteer health professionals in Sierra Leone's health sector. In Kenema Government Hospital, for example, 124 of the 174 health care staff are volunteers who do not get pay or other incentives in exchange for lobbying people with more clout in the recruitment process. Any volunteer who does not profit from the Health Care manager's recommendation must bribe his or her way through Freetown. Medical staff are evaluated every six months, and senior DHMT staff conduct unannounced visits regularly.

Although the Ministry of Health and Sanitation continues to train vital personnel to improve service delivery, there is no clear career path for professionals, particularly those in rural areas. For health personnel, there are minimal performance management tools in place. Specialists, on the other hand, are promoted based on their track record of performance. Employees should be promoted based on their competence, qualification, experience, and track record of performance. House Officer (HO), Medical Officer (MO), Senior Medical Officer (SMO), Specialist, Senior Specialist, Consultant, Deputy Chief Medical Officer (DCMO), and Chief Medical Officer are the ranks of doctors (CMO). Nurse, Staff Nurse, Sister, Senior Sister, Assistant Matron, Matron, Assistant Chief Nursing Officer, and Chief Nursing Officer are the nursing positions. This hierarchy demonstrates the limitation of career advancement for nonmedical public health specialists.

There is currently no health insurance for health care professionals, although work is being done to create one. The roles of health care stakeholders such as medical professionals, the general public, and MDAs and CBOs differ depending on the community. For communities with PHUs, there are Village Development Committees (VDCs) and Facility Management Committees (FMCs) that assist with facility management in collaboration with the assigned health care professionals; however, most locals who are not members of the VDCs and FMCs are unaware of their functions. While medical professionals provide professional medical services to the communities, VDCs and FMCs assist in the oversight of drug supplies and other gifts from partners like IRC and MARIE STOPES. These are organizations that collaborate with the MoHS to support health-related programs and activities.

In Sierra Leone, there are approximately fifty non-governmental organizations (NGOs) working in the field of health. Their activities include, but are not limited to, community-based health activities such as health groups (women's groups, for example), sensitization/information, education, communication (IEC)/behaviour change communication (BCC), etc., as well as the construction of new PHUs and the rehabilitation of old ones. Supply of drugs, supplies, and equipment to PHUs and hospitals, promotion and support of health education, nutritional,

reproductive, and child health, malaria, HIV/AIDS, and other MoHS programs, in-service training of health staff and incentives, logistics (vehicles, motorcycles), and general logistic support at all levels

The District Health Sisters are responsible for transporting immunizations to the numerous Peripheral Health Units under their supervision, although they do not always do so. Junior nurses working in rural communities pay for their transportation to obtain vaccines and return to their health facilities. When this occurs, the vaccines do not reach the health facilities in time because the health workers in those rural villages do not return early, and the vaccines have expired by the time they return to the health facilities.

At the District level, the COVID-19 District Coordinator and the Finance and Administrative

Officer are entirely responsible for the management of COVID-19 finances. Only the two are in charge of overseeing and accounting for the District's funds.

The National COVID-19 Emergency Response Centre (NaCOVERC), which was established as a Presidential task force, has primary responsibility for managing the epidemic on a national scale and has district structures that use existing district disaster management committees with coordinators appointed by the national coordinator. The devolved structure was tasked with mobilizing both human and material resources to stop the disease's spread in the district.

SECTION 3:

Political Economy of the Healthcare Sector



SECTION 3:

Political Economy of the Healthcare Sector

The Sierra Leone civil war, which lasted a decade, left the country's health-care system in an abysmal state. During the battle, the rebels controlled the majority of rural areas, and health care was primarily provided through emergency help provided by humanitarian organizations. These groups assisted in the construction and operation of temporary health facilities by hiring local and foreign health workers who were paid from their funds rather than government funds. However, most of these agencies had no exit strategy, and their departure caused a significant financial gap because the post-conflict economy was not strong enough to absorb the deficit in health spending.

The economy suffered as a result of the fighting, as well as the fact that the government now had to actively assist the health sector as humanitarian organizations withdrew. In 2002, government health expenditures per capita were as low as \$29, the lowest in the sub-region at the time. The economy's poor performance was seen in its need for foreign budgetary assistance to fund the sector.

The Ministry of Health and Sanitation is the country's line ministry in charge of health (MoHS). The Ministry of Health and Sanitation is divided into three tiers: the Minister, two Deputy Ministers of Health and Sanitation, the Chief Medical Officer/Permanent Secretary, and their deputies at the policy level; Directors and their deputies at the technical guidance level; and managers, District Medical Officers, Medical Superintendents, and other staff at the operational level. The MoHS includes several administrative directorates that are responsible for policy formation as well as oversight.

During the 2014 Ebola outbreak and the COVID-19 pandemic, the mismanagement and underfunding of the health system reared their ugly head. These public emergencies exposed the sector's long-standing human, logistical, and infrastructural resource shortages. The status quo was also reaffirmed, as the country ranks towards the bottom of international performance

indicators/rankings. The country's economic condition, on the other hand, had been deteriorating previous to COVID-19, exacerbating the situation.

Worse, the country's ranking in the United Nations Development Programme's (UNDP) Human Development Index (HDI) of 182 out of 189 countries is not encouraging, as it has been for some time.

To change the narrative in the health sector, the government launched the Free Health Care Initiative (FHCI) in April 2010 intending cover and cater for under-five children and pregnant and lactating mothers. However, the policy has had little impact on maternal and mortality deaths in the country, and there has been no significant shift in the global index. The FHCI program grew out of the Campaign for Reducing Maternal, Newborn, and Child Mortality (CARMMA), which was launched in March 2010.

MoHS has received UNFPA's support as one of the major contributors to the FHCI's implementation. The UNFPA, in collaboration with the following institutions, made extensively interventions to ensure the program's success: The Global Programme on Reproductive Health Commodity Security (GPRHCS) and Maternal Health Trust Fund (MHTF), as well as support from the United Kingdom's Department of Foreign International Development (DFID), Canada's International Development Agency (CIDA), the European Union (EU), Irish Aid, the African Development Bank (AfDB), and the Multi-Donor Trust Fund (MDTF) under the United Nations Joint Vision (UNJV), have all helped the health sector.

To assist with the management of FHCI drugs, Sierra Leone's national health sector supply chain management body, the National Medical Supplies Agency (NMSA) (formerly the National Pharmaceutical Procurement Unit (NPPU)), was reformed with support from DFID, World Bank, USAID, the Global Fund, and UNICEF.

The findings found that, while access to health care has improved, the cost of the service and the supply of free pharmaceuticals has not. The majority of respondents stated that they still pay for health services and that FHCI medications are rarely available in medical institutions. Patients allege health care employees conspiring with pharmaceutical stores to steal drugs intended for the FHCI. According to reports, regardless of the MoHS's recruitment of trained and qualified workers in sectors, the majority of those hired are either university graduates with no skill or the needed experience to carry out the duty.

MoHS has made great strides in policy formation in the health sector, resulting in improved results and favourable outcomes. According to the comments of respondents, the short-term effects of these measures appear to have accounted for little or no immediate influence in terms of its sustainability. During the COVID-19 outbreak, for example, the Directorate of Health Emergency and Security was established, but its function has not generated the promised dividend. The same is true for the establishment of National Emergency Medical Services (NEMS), which would oversee ambulance services.

During the poll, health workers stated that their working circumstances are still poor in comparison to their colleagues in the sub-region. The workers recalled that their union had made representations to the central government regarding their working conditions and an improved working environment. Unfortunately, none of these concerns had received the attention they deserved. Furthermore, the profession has not been immune to political meddling and intimidation. The health workers claimed that the majority of their colleagues, even those in administrative roles, had their jobs changed due to their supposed political ties.

This, according to the poll, has hampered the successful implementation of most programs in the sector. Respondents in Karene District stated that the current government pays little attention to that district in terms of funding because it believes that health care resources will be wasted on political opposition residents who will not vote for them. Cleaners in the Pujehun District were denied monthly salaries because they were

thought to be sympathizers of an opposition party. Human resources continue to face a severe scarcity of skilled individuals, as most excellent and distinguished graduates are drawn to western countries by lucrative job opportunities. People still suffer from the centralized system of coming to Freetown for the full process even when they are better qualified with every piece of documentation in hand.

According to the survey results, the level of corruption in the health industry is extremely high. It was alleged that necessary pharmaceuticals, medical supplies, dietary supplements, and palliatives were frequently misappropriated. Respondents are confident that if MoHS implements effective accountability procedures, the reoccurrence will be greatly reduced or eliminated. They are surprised since, in their opinion, such behaviour should not occur in the health industry. According to the Portloko District Health Management Team, the Council often requires 30-40% of devolved money before providing the DHMT access to the monies.

A scenario that has had a negative impact on healthcare delivery. Even for free health care recipients, medications, and IPC materials, money is sought for consultation. 135 respondents, or around 58 per cent, reported that they had paid money for health care services at government facilities, and 64.9 per cent of these respondents are exempt from all payments. The task here is to build an equitable and pro-poor healthcare finance policy and approach. There has been no comprehensive research on health expenditure in Sierra Leone's poorest communities.

According to survey results, despite apprehension and negative marketing about the COVID-19 vaccine's effects, many individuals were willing to be vaccinated, despite a limited supply of the vaccine and the lack of suitable storage facilities in remote areas.

Many survey studies found that the lack of continuous power supply in rural regions was to a considerable part responsible for the low incidence of vaccination. In all, 2.5 per cent of respondents indicated they had paid for COVID-19 vaccination when it should have been free. In Freetown, health staff were found selling COVID-19 vaccination cards to people who refused to take the vaccine but need the card as proof of immunization to gain access to certain services.

SECTION 4:

Laws and Legislative Oversight on Healthcare



SECTION 4:

Laws and Legislative Oversight on Healthcare

Sierra Leone's Parliament has legislative authority under the country's 1991 constitution. The President is a member of Parliament and has never been called before it. Parliament debates and approves budgets, laws, and policies for implementation. There are legislative health and public accounts oversight committees. These committees are responsible for overseeing the Ministry of Health and its devolved agencies, as well as for pioneering major legislation affecting them. The oversight functions of Parliament have been inadequate.

NO.	Legislation	Key Provisions	Benefits
1	The Sierra Leone Health Service Commission	<p>Section 2(1) It establishes the Sierra Leone Health Service Commission.</p> <p>Section 9(1): The object for which the commission is established is to help in the implementation of national policies, programmes, and projects for the delivery of healthcare services throughout Sierra Leone.</p> <p>(2) (b): Ensure that people have access to high-quality healthcare services.</p> <p>(c) The minister appoints the professional staff of government healthcare facilities and the ministry and also, determines the remuneration and other conditions of service of the staff;</p> <p>(d) Recommend to the Minister the fees to be charged for the services rendered by Government healthcare facilities</p> <p>(e) To assist in the management of various projects and programs in the health sector, as well as to ensure that services are delivered effectively and efficiently.</p> <p>(f) Monitor and supervise the Boards of the Hospitals</p>	<ol style="list-style-type: none"> 1. Ensure independent monitoring and the implementation of healthcare projects. 2. Provide expert Human resource duties for the Ministry free of bias

NO.	Legislation	Key Provisions	Benefits
2	The Medical Practitioners and Dental Surgeons Act 2008	<p>Section 1:</p> <p>Section 3: (d) Registering and licensing of all healthcare facilities in accordance with such standards as the Council may, with the approval of the Minister.</p> <p>(e) Monitoring and periodically inspecting all health care facilities to ensure that they adhere to established medical and dental standards and practices.</p> <p>(g) Closing down private health care facilities which (i) are operated without being registered and licensed under section 23A; or (ii) Do not meet the established standards of medical and dental practices.</p>	This Act repealed and replaced the obsolete 1994 Act.
3	The Pharmacy and Drug Act 2001	<p>Section 2(1) establishes the Pharmacy Board</p> <p>Section 3 It also sets up the Disciplinary Committee to keep track of what pharmacists, pharmacy technicians, and other people who work in the pharmacy business are doing.</p> <p>Section 8 ensures that standards are maintained by promoting the proper training and examination of students.</p>	The Act ensures the sustainability and ethical standards in pharmacy profession are maintained at all times.

According to the survey results, the multi-stakeholder method is used to design the legal framework for the health sector. According to the research, this strategy has been successful and has made the execution of most policies in the sector, such as the Health Sector Human Resource Management Policy 2017-2021, easier and more workable. These achievements have been made possible by consulting all stakeholders and incorporating their feedback into policy development and formulation. However, at the theoretical level, the Parliamentary Oversight Committee on Health is the principal authority, while the City and District Councils are in charge at the local government level. The same strata are used for monitoring and oversight roles in the sector's program and activity implementation. This monitoring, however, is ineffective. Furthermore, DHMTs,

Councils, CBOs, INGOs, and community stakeholders are included in some places to actively participate in the process. Some health policies in Sierra Leone are now out of date and must be revised to address developing challenges. Among them are the following:

- 1 National Child Health Policy (2007)
- 2 National Cost Recovery Policy (2006)
- 3 National Environmental Health Policy (2000)
- 4 National Food and Nutrition Policy (2003)
- 5 National Health Care Waste Management Programme Policy (2007)
- 6 National Health Education Policy (2000)
- 7 National HIV-AIDS Policy (2002)

- 8 National Human Resource Policy (2006)
- 9 National Malaria Policy (2005)
- 10 National Medicines Policy of Sierra Leone (2004)
- 11 National Policy on Immunization (2002)
- 12 National Policy on Traditional Medicine (2007)
- 13 Reproductive Health Policy (2007)
- 14 Mental Health Policy (2009)
- 15 Non-Communicable Diseases Policy
- 16 Free health care Policy (2009).

According to the poll results, the federal government used the Ebola response experience to handle and manage the COVID-19 reaction across the country to a considerable extent.

SECTION 5:

Healthcare Policy, Funding and Gaps

COVID-19

SECTION 5:

Healthcare Policy, Funding and Gaps

According to the survey results, the health sector is primarily dependent on the annual budget granted to the MoHS by the Ministry of Finance MoF at the budget hearing, which leads to it being read in Parliament and then debated by Members of Parliament before being approved. According to sources, while the MoHS budget contributes to around 11% of the national budget, it falls 4 percentage points short of the Abuja Declaration target.

According to reports, the MoHS requested an extremely ambitious budget for the fiscal year 2022 to meet the Abuja objective of 15% of the national budget. The request was for Le1.3 trillion, but only (Le1, 263,298) was allocated, with the government promising to raise spending by close to 14 per cent. The MoHS proposed to mainly fund the Public Investment Program (PIP) in 2022, which was meant to greatly improve hospital service delivery by ensuring continuous drug supply and increased specialized health professional availability. PIP and the recurrent budget were estimated to cost Le536 billion and Le245 billion in 2022, respectively. The annual budget limit was Le55.7 billion.

The health sector also received funding from other sources, such as donations from NGOs (partners), consulting fees, patient treatments, and so on. The majority of the funds obtained by the MoHS are used to cover the operating costs of the facilities throughout the country, as well as to fund the MoHS's salary bill, which stands at Le488.3 billion for the current payroll of 13,348 employees as of 2022. According to the findings, the MoHS would require approximately 25,011 employees to completely offer the basic package of essential health services and attain universal health coverage. Various critical health staff are missing in some districts. Medical Officers, State Enrolled Community Health Nurses, Specialist Nurses (Public Health Sister/Officers), Pharmacists, and Laboratory Assistants are among the workforce members. A Community Health Officer serves the majority of the villages. Midwives are primarily stationed in provincial centres, depriving the remainder of the country

of essential services. As a result, MCH Aides, who are auxiliary female nurses trained to provide community midwifery services, serve several health facilities.

Due to the funding gap, the MoHS must also carry out equipment purchases, maintain the continuous supply of electricity and water to its sites around the country, and provide fuel for vehicles and generators, among other things. The primary focus is on nutrition, diet, hygiene, and salaries, with less emphasis on maintenance because most development partners contribute to the sector in the form of drug, tool, and equipment acquisition.

Donations and financing from the private sector are scarce. IRC, MSF, UNICEF, WHO UKAid, and others are generally partners who supplement the government's work, and their donations are used to provide quality health services to citizens, such as maternity and paediatrics. The disadvantage of the majority of contributions is the absence of citizen participation in the process. The M&E Officer monitors and evaluates healthcare spending, as do external audits conducted by both the MoHS and other partners such as civil society organizations. According to the reports, there is often a delay in the disbursement of allocations from the MoF to pay for the MoHS's activities. Many reports suggest that these delays have serious effects on the administration of services to citizens.

In 2020, most facilities reported getting only two-quarters of their allocation, resulting in strikes and demonstrations among service providers such as housekeeping, dietary and nutrition, and security. Because of this financing deficit, free healthcare drugs are never adequate. Beneficiaries continue to purchase 60% of the drugs when they are accessible and 100% when the drugs run out. Usually, drugs run out after the first month in the 3 quarters. The medications provided are insufficient to treat critical instances. A 7-month-old pregnant woman died in a major referral hospital in March 2021 because she couldn't afford the procedure

charge to wash out a dead baby in her womb. The two major elements that comprise the economic makeup of health expenditure are recurring and capital expenses. Personnel emoluments, products and services, and current transfers are examples of recurring expenditures (grants). Capital expenditure, on the other hand, includes both capital transfers and domestic capital spending. Recurrent spending consistently outnumbers capital spending.

Between 2016 and 2021, total recurring and capital spending was Le1.43 trillion. 90% (Le1.28 trillion) of the total was spent on recurrent expenses, whereas 10% (Le147.71 billion) was spent on capital investments. The GoSL's health spending benefited both tertiary and secondary care. For the past five years, an average of Le282.69 billion has been spent on critical functions to fulfil healthcare demands. Administrative services received Le207.09 billion, accounting for 73% of the average total. Secondary and tertiary care services received an average of 12% of total expenditure (Le35.79 billion). Primary health care (PHC) received Le9.21 billion, accounting for only 3% of total spending.

The GoSL must give special attention to PHC because it is critical to achieving Universal Health Coverage (UHC). Because it relied on external public finance from donors, the GoSL does not fully fund stand-alone programs such as Maternal and Child Health, STI/HIV/AIDS Prevention and Control, and Malaria Prevention and Control. Gavi, the World Bank,^{10,11} WHO,

UNICEF, JICA, CDC, Global Fund, and IsDB supplied more than 93 per cent of off-budget finance for these and other sector programs, raising concerns about sustainability. MoHS's average budget execution rate for the 2015-2019 period is 98.2 per cent, however, there is potential for improvement in terms of health outcomes. In terms of execution performance, MoHS's capital and recurring expenditures produce inconsistent results. While capital expenditure fell short by Le70.4 billion (32%), recurrent expenditure increased by Le51.2 billion (over four per cent).

Secondary and tertiary care services received an average of 12% of total expenditure (Le35.79 billion). Primary health care (PHC) received Le9.21 billion, accounting for only 3% of total spending.

10. World Bank. 2019. Technical Efficiency of Health Facilities in Sierra Leone: A Data Envelopment Analysis.

11. World Bank. World Development Indicators (WDI). 2021 Available <https://datacatalog.worldbank.org/dataset/world-development-indicators>. Accessed April 13, 2021.

Sierra Leone's Health Expenditure Indicators, 2015–2018

Health Expenditure Indicators	2015	2016	2017	2018	Growth Rate 2015–2018
Domestic general government health expenditure (% of current health expenditure)	8.04	11.17	11.15	9.71	6.29%
Domestic general government health expenditure (% of GDP)	1.64	1.85	1.85	1.56	–1.67%
Domestic general government health expenditure (% of general government expenditure)	7.91	7.91	7.91	7.25	–2.90%
Domestic general government health expenditure per capita (current US\$)	9.72	9.73	9.21	8.33	–5.14%
Domestic general government health expenditure per capita, PPP (current international \$)	23.42	28.84	28.47	25.00	2.18%
Domestic private health expenditure (% of current health expenditure)	41.79	57.27	54.84	64.41	14.42%
Domestic private health expenditure per capita (current US\$)	50.53	49.88	45.27	55.25	2.98%
Domestic private health expenditure per capita, PPP (current international \$)	121.77	147.84	140.01	165.74	10.28%
External health expenditure (% of total current health expenditure)	50.18	31.56	34.01	25.88	–22.07%
External health expenditure per capita (current US\$)	60.67	27.49	28.07	22.20	–33.51%
External health expenditure per capita, PPP (current international \$)	146.22	81.46	86.82	66.59	–26.22%
Out-of-pocket expenditure (% of current health expenditure)	36.70	41.55	40.92	44.78	6.63%

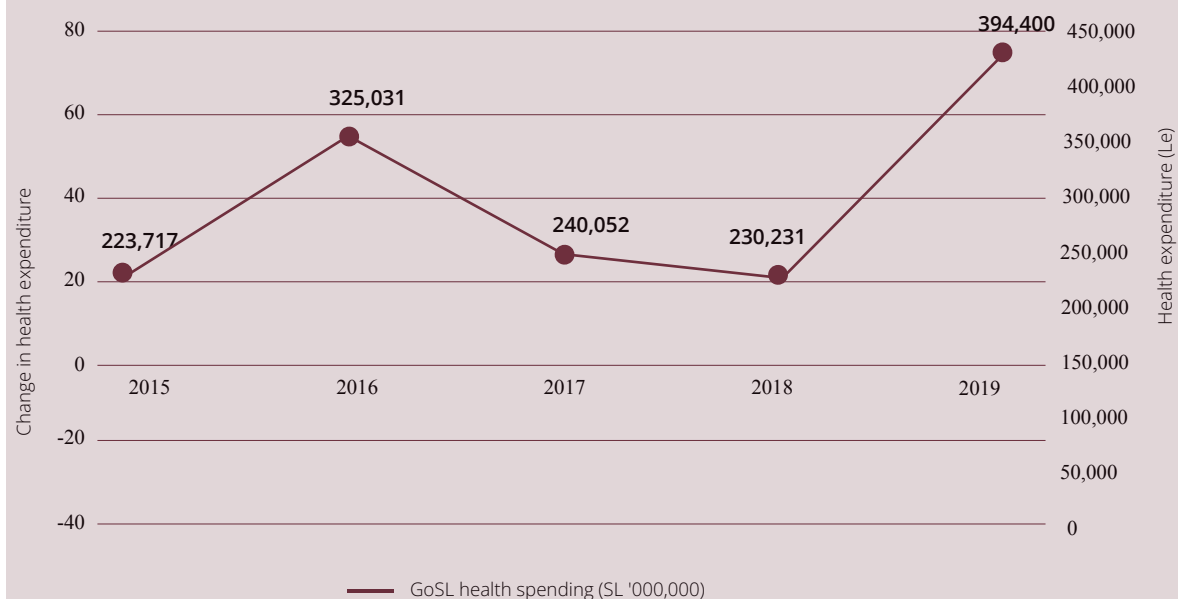
Source: WDI

In 2019, public spending on health is roughly 6%, which compares favourably to other key sectors. Public health expenditure ranked second among the top five spending entities as follows:

In 2019, the Ministries of Education, Science, and Technology (11%), Ministry of Health and Sanitation (6.49%),³ Ministry of Works, Housing, and Infrastructure (5.06%) Ministry of Technical and Higher Education (4.28%) and Foreign Affairs and International Cooperation (4.26%).

Sierra Leone's public health spending is higher than that of its West African sub-regional neighbours, yet health outcomes are poorer. Sierra Leone invests more in health, both public and private, than some of its West African counterparts. When comparable data are available, total health expenditure in 2018 was greater than 5% (5.72%) of GDP. It is higher than the West African sub-regional average (4.85 per cent), the LIC average (5.34 per cent), and the Sub-Saharan African average (4.85 per cent).

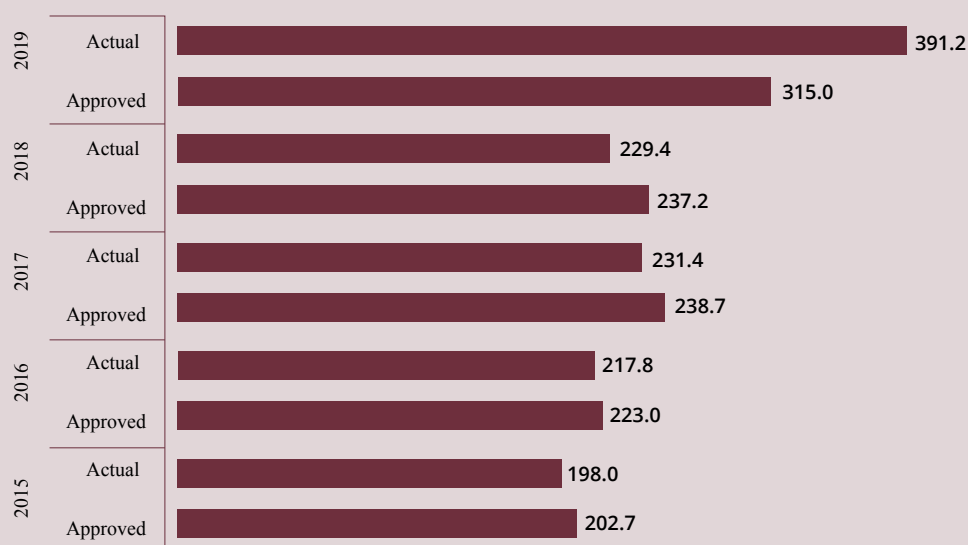
Trends in Annual GoSL Health Expenditure, 2013-2019



Health and Other Social Sectors Compared, 2015–2019 (Le in Million)

Ministry	2015	2016	2017	2018	2019	Total	Average	Per cent of Total
Education Science & Technology	597,305	691,894	672,994	789,934	668,105	3,420,231	684,046	43.47
Health & Sanitation	223,717	325,031	240,052	230,231	394,400	1,413,430	282,686	17.97
Labour, Employment & Soc. Security	6,404	7,306	8,314	6,880	7,754	36,568	7,332	0.47
Soc. Welfare, Gender & Children's Affairs	12,148	12,792	12,811	15,977	37,971	91,699	18,340	1.17
Sports	5,999	11,901	7,826	16,765	28,410	70,900	14,180	0.90
Technical & Higher Education					260,015	54.84	260,015	3.30
Tourism & Cultural Affairs	5,485	9,348	4,664	4,364	2,961	45.27	5,364	0.34
Works, Housing & Infrastructure	412,273	739,695	515,634	517,111	307,408	2,492,221	498,424	31.68
Youth Affairs	6,009	15,427	5,868	11,333	16,959	55,596	11,119	0.71
Total	1,269,340	1,813,394	1,468,163	1,592,594	1,723,984	7,867,474	1,575,495	100

MoHS Budget Execution Performance (Actual vs . Approved Budget), 2015–2019



Confronting the problems that DHMTs face as a cornerstone of health service delivery will assist to enhance the health of the public. The decentralized approach is based on the premise that it empowers local communities, involves people in the development process, and develops local ownership—all of which might be considered defining strengths for making health service delivery responsive to Sierra Leoneans' needs. In actuality, however, the system is riddled with flaws that prevent it from functioning properly.

District health facilities' performance is hampered by a lack of human resources, infrastructure, and technical capabilities. Health and administrative personnel are in low supply. Many facilities, including hospitals, report frequent medicine stockouts, and crucial equipment is frequently unavailable. Because it lacks an incinerator, the Pujehun district hospital, for example, uses open pit burning. The majority of institutions report going without power for 24 hours. This issue is frequent at CHCs, where other infrastructure difficulties include insufficient or non-functional laboratory equipment and vaccine storage freezers and fridges. Maternity wards, postnatal rooms, and examination rooms have insufficient beds and, at times, no running water.

Financial management, procurement, internal audit, M&E, HMIS, and asset management

capabilities are lacking in DHMTs. These constraints, when combined with fund flow limitations, generate budget execution performance challenges for DHMTs.

Central government grants are expected to be distributed quarterly (four times a year) via the intergovernmental fiscal transfer mechanism. However, LCs frequently do not get the whole amount of budgeted transfers, and the timing of the transfers is frequently delayed. As a result, the ability of the councils (and thus the DHMTs) to implement their budget is jeopardized.¹ These fund flow constraints were discovered through interviews with three LCs in three separate regions. The four quarterly tranches of the proposed budget for 2019 were received in one LC, but with delays. In another case, only three of four tranches were delivered. Only the first and second quarter tranches were received in the third LC. Part of the problem could be attributed to reporting delays as well as inaccuracies in spending requests submitted to the Accountant General. **According to the Office of the Accountant General, hospitals are known for their lateness in submitting their expense reports. The problem could also be a lack of enforcement of policy compliance.**

Taking proactive steps to address fund flow difficulties, as well as increasing the capacities of district health facilities and DHMTs will enable them to function properly.

1. Ministry of Health and Sanitation Sierra Leone, Directorate of Planning, Policy & Information (DPPI). Sierra Leone Health PER DPPI Input (Draft). April 2020.

SECTION 6:

***Citizen Data and Voices
on Healthcare Access
and Accountability***

SECTION 6:

Citizen Data and Voices on Healthcare Access and Accountability

231 respondents in this area were mostly service users/beneficiaries, such as pregnant women, breastfeeding moms, parents of children under the age of five, people with disabilities, and general patients. The majority of respondents indicated they prefer going to government health institutions because of the free health care and the low cost of treatment. The majority of respondents indicated they were handled well and received good medical treatment throughout their visit. A single type of medicine to treat malaria and typhoid, on the other hand, could be assumed to be a good treatment for poor families living in rural regions. This was shown when more than half of the respondents denied seeing the facilities furnished with pharmaceuticals and medical equipment.

Over 58 per cent of respondents indicated they have paid money for services acquired with medications, with consultation costs being the two most expensive. The majority stated that they are not involved in decision-making in their local healthcare governance, and approximately 73% stated that they are unaware of how monies are received and spent in health facilities.

Gender of Respondent

232 responses

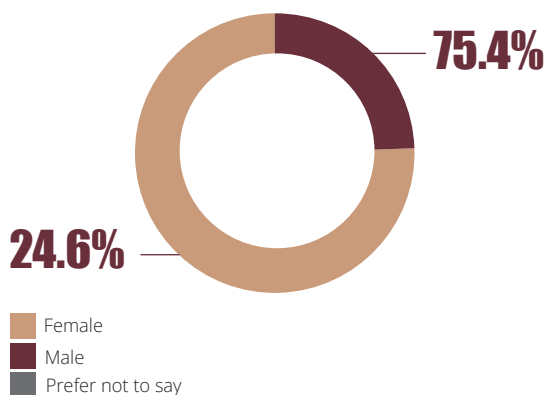


Figure 1 The gender of the respondents sampled during the survey is depicted above.

Females visit health care facilities in the country regularly. 175 of the 232 respondents randomly sampled during the study were females, accounting for approximately 75.4 per cent of the respondents. The remaining 24 respondents were males, accounting for approximately 24.6 per cent of the total.

Age Bracket of Respondent

232 responses

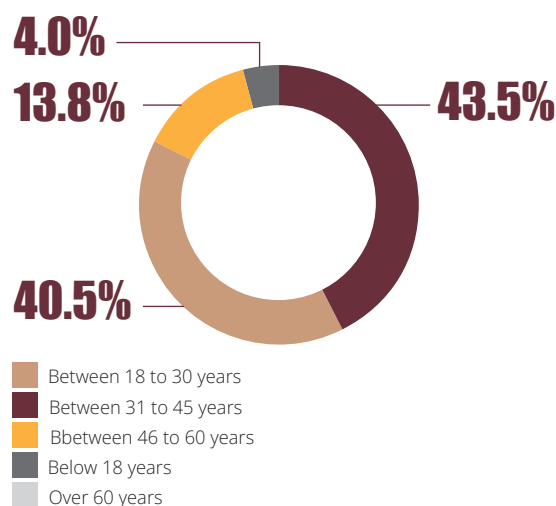


Figure 2 above depicted the age distribution of the survey respondents who regularly visited government health institutions across the country. According to the data, around 101 of the respondents (or 43.5 per cent) are between the ages of 31 and 45. This is followed by 94 respondents, who range in age from 18 to 30 years old and account for 40.5 per cent of all respondents. However, respondents aged 46 to 60 and 18 and under accounted for 13.8 per cent and 4% of all respondents, respectively.

Which type of Health facility do you frequently visit?

231 responses

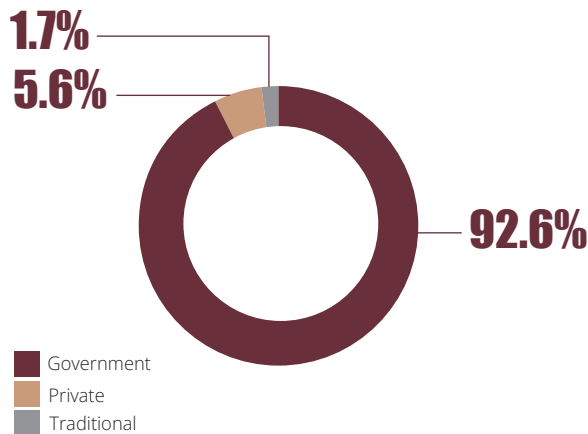


Figure 3 depicted the respondents' chosen health care institution when they were ill or in need of health services. Surprisingly, about 214 respondents (92.6 per cent) answered that they prefer to attend government medical facilities for health treatment. While approximately 13 respondents (5.6 per cent) indicated a preference for private facilities. According to the research, most respondents prefer government hospitals as their first choice, with private hospitals as an alternative. Traditional medicine, on the other hand, is preferred by approximately 4 of the respondents, or roughly 1.7 per cent. Although the data primarily includes respondents from rural areas, it appears that the MoHS has achieved great strides in the ratio of access to health care across the country. The majority of respondents responded that they prefer government-run health care facilities because of the FHC and because they are very affordable, have professional staff, are very close, and in most cases are the only accessible alternative in their neighbourhood.

Did you receive good medical care during your visit?

230 responses

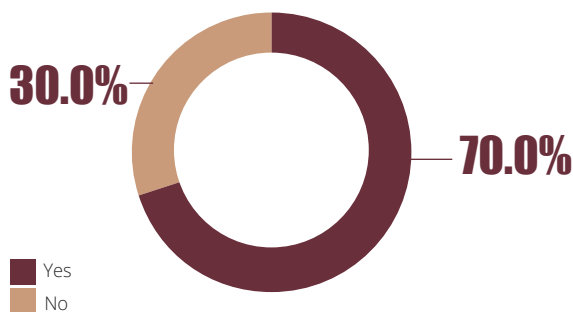


Figure 4 depicts the responses of those who chose government health care facilities. Of the 230 individuals polled, 161 (or 70%) said they

received satisfactory service during their visit. However, approximately 69 of the respondents (30%) indicated that they did not receive satisfactory services due to the following reasons: a lack of drugs in the hospital; a lack of medical equipment to diagnose their ailments; corruption; a lack of professionalism by health care workers; and the absence of health care workers, among others. Though the input represents significantly more than the sample size, MoHS must address these concerns for the advances gained thus far to be sustained.

Did the health care workers like Doctors and nurses treated you right during your visits?

231 responses

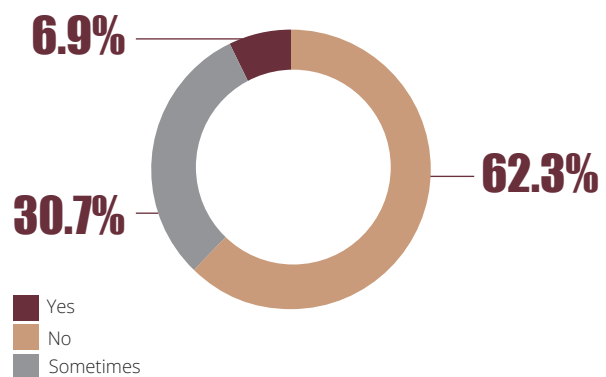
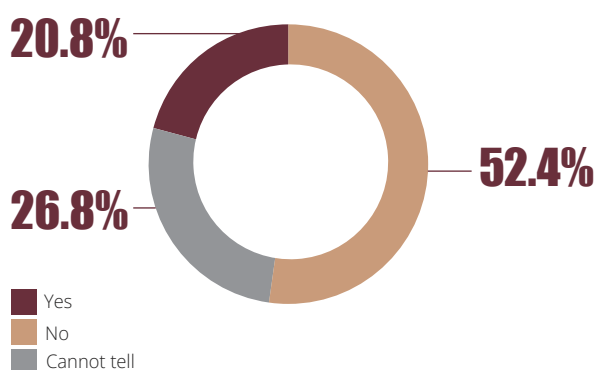


Figure 5 shows how patients felt about the care they received from the medical staff during their time at the facility. Sixty-two per cent of the people who took part in the survey said they were satisfied with the care they received from the doctors and nurses at the hospital where they went. However, roughly 30.7 per cent (or 71) of the respondents reported receiving better treatment from doctors or nurses at some point. Some 6.9 per cent of the respondents stated that they did not receive better treatment from the doctors and nurses. A quarter of those surveyed appear to fall into this category, but for a profession that prides itself on putting the needs of its patients first, this is not good news.

Was the health facility equipped with adequate drugs and equipment to respond to the individual cases reported?

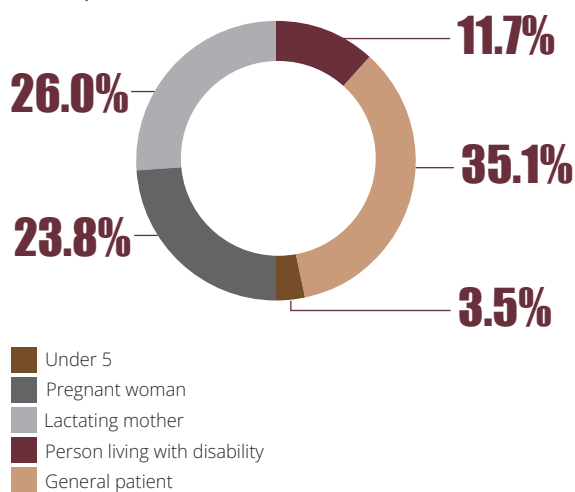
231 responses



Respondents' opinions on the medications and medical equipment used by hospitals across the country to treat the patients they encountered are depicted in Figure 6. At least 52.4 per cent of those who answered this question said there were not enough drugs and medical supplies to effectively address the reported instances when visiting a health institution. Respondents' views create a blurry picture of health care facilities, as 62 of the respondents, or roughly 26%, claimed that they couldn't identify whether the facilities had medical supplies or equipment during their visit. Of the rest of the surveyors, 48 (or 20.8%) said that there were drug supplies and medical equipment on hand. According to the information presented above, the health sector faces challenges in procuring and supplying medical supplies necessary to sustain health care delivery across the country, which is a critical objective of the government in developing human capital.

Which category of patients did you belong to at the time of visit?

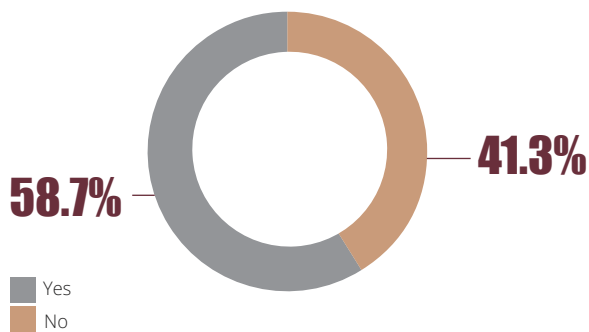
231 responses



During the study, data was gathered on the various types of patients who visited the healthcare institutions shown in Figure 7. Nearly one-third (35.1 per cent) of those surveyed said they were general patients. Pregnant women accounted for 23.8 per cent of the respondents in this study. In addition, 26% of those who answered the survey were lactating mothers, 60 of them. People with disabilities and children under the age of five made up the remaining 27 per cent (11.7%) and 8 per cent (3.5 per cent), respectively. Overall, the statistics showed that people who were enrolled in the government's FHC program tended to make regular trips to medical institutions. The timely delivery of pharmaceuticals and medical supplies must be addressed by the Ministry of Health and its partners in the sector if maternal and child mortality statistics are to be improved. According to the results of the poll, those who are most at risk and in need of medical care go to public health facilities, which are frequently short on drugs and equipment.

Did you pay any money for the services rendered to you?

230 responses



Survey respondents were surveyed to determine whether or not they paid for their medical care while visiting government health facilities, as shown in Figure 8. Interestingly, 135 of the respondents, or 58%, stated that they had paid for the services, which is very high. There were just 95 people who said they hadn't paid or 41.3 per cent of replies. Further, the respondents were asked to provide information on the services they had paid for. Many people studied were found to have paid for drugs, vaccinations, beds, and other medical supplies that do not incur a price, as depicted in Figure 7 of the study.

Is there a dedicated team of senior officers with the sole responsibility to monitor the work of the health facility?

230 responses

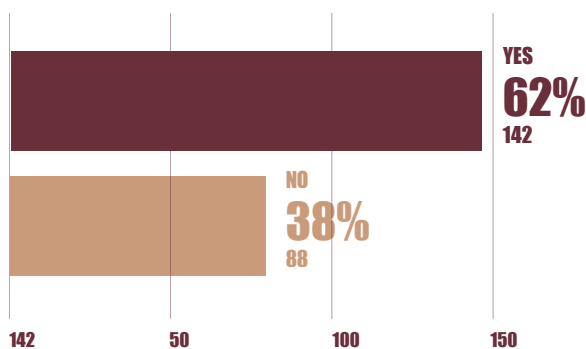
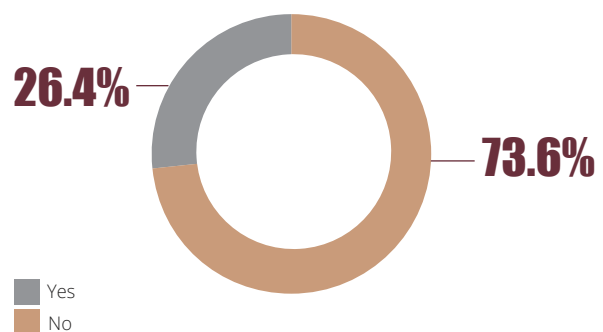


Figure 9 depicts the findings of a survey asking participants whether they believe that healthcare institutions are under the watchful eye of a team of senior officers. Healthcare facilities are being supervised by dedicated workers in 62% of cases, according to the survey. However, just 88 of the respondents, or around 38.4% of the total, agreed with this assessment. The survey also asked respondents who responded that the health facilities were being monitored to provide details about the team responsible for such

oversight. In general, the DHMT monitoring team provides oversight for hospitals under their authority, whereas the CHOs provide oversight for the PHUs. A lack of unexpected oversights suggests that they are not working. Even if only health facilities are examined, those who say no claim that their attitude and the noticeable absence of medical officers in their workstations would not be apparent.

Do you know how funds for your health facility come and spent?

231 responses



Assessing respondents' understanding of where and how their medical facility's money comes from is shown in Figure 10. The results of the study revealed a widening gap in respondents' understanding of how their local government health facilities are funded and how those funds are spent. About 170 people, or 73%, of the 231 who took the survey said they had no idea who paid for their local hospital. On the other hand, 61 people, or around 26.4% of those who took the poll, said they did. This is a troubling report that has the potential to play a big role in patients being exploited by their caregivers. If limitations to transparency in health sector funding and beneficiaries' participation in some decision-making and management of health facilities are removed, this problem will be resolved or limited.

Have you been given COVID 19 vaccine

232 responses

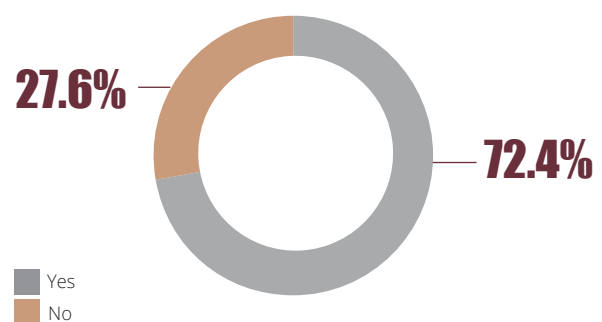


Figure 11 depicts statistics data on the administration of COVID-19 vaccines across the country. In response to this critical question, 168 of the 232 respondents (72.4 per cent) stated that they had received the COVID-19 vaccine, while 64 respondents (27.6 per cent) stated that they had not. Despite the scaremongering and negative campaigns by people about the vaccine's safety and side effects, the data shows that the MoHS and NaCOVERC have achieved substantial breakthroughs in the vaccine's dissemination.

Are you aware about funds provided for the fight against COVID 19 in your distinct, chiefdom or town?

232 responses

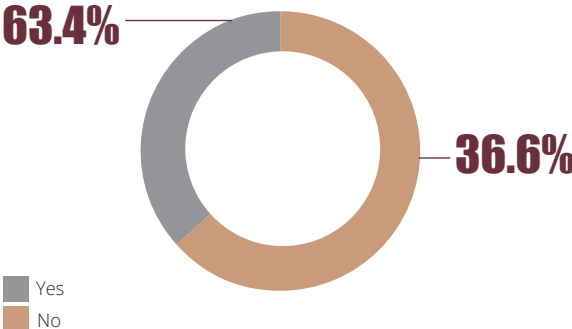


Figure 12 essentially determines if respondents can relate to the information that financing is being provided for the fight against COVID-19 in their area. According to the survey data, there is a scarcity of information on the subject. For example, 147 of the 232 respondents selected, or around 63.4 per cent, stated that they are unaware of monies granted to local hospitals or the DHMT in their districts to combat COVID-19.

The opacity surrounding public institution financing is the reason for worry and is mostly responsible for major government interventions and donor support not reaching the intended beneficiaries.

Are ordinary citizens in your district, chiefdom or locality taking part in decisions regarding health?

230 responses

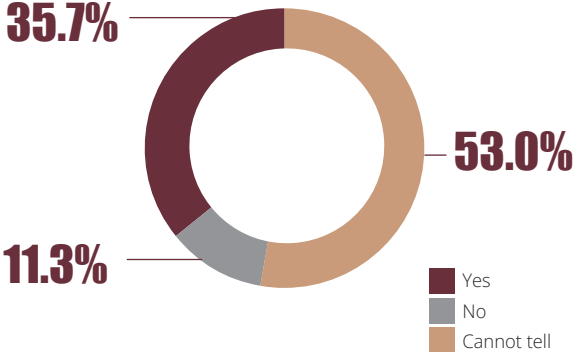


Figure 13 depicts survey data collected to examine the engagement of ordinary persons in decision-making at various levels of health care management. Among the 230 individuals polled, 122 (or 53 per cent) said they don't know whether regular folks are involved in decision-making. However, 82 of the respondents (35.7 per cent) stated that residents are active in healthcare decision-making in their community. In response to this question, 26 respondents (11.3 per cent) responded that they are unaware. The respondents who said they didn't know and those who said no accounted for more than 60% of those polled. Non-citizen engagement appears to be marginal, leaving the possibility for abuse by those in power.

14. What do you pay for among the following in the health facility? (Multiply choice option)

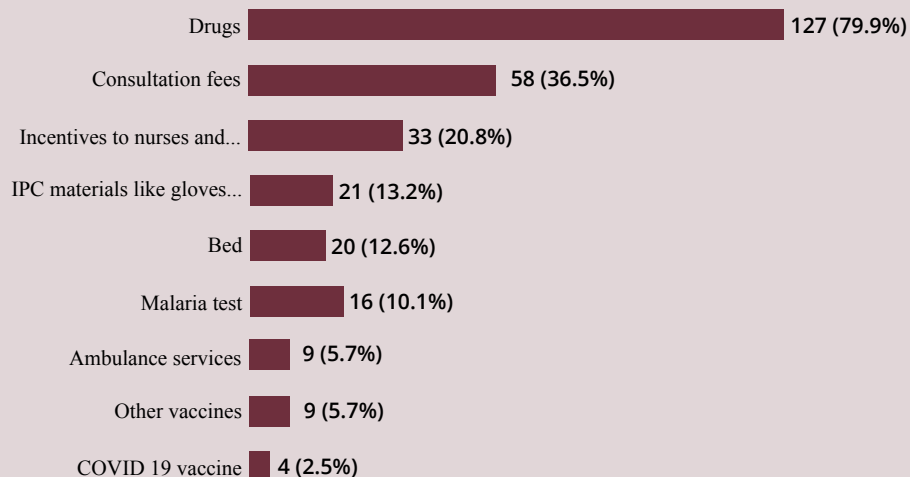


Figure 14 depicts data from an analysis of the services that respondents allegedly pay for when they visit health care institutions around the country. According to the data, 127 of the 159 respondents sampled, or around 79.9 per cent, paid for medicines. Furthermore, around 58 respondents (36.5 per cent) stated that they pay consulting fees. This was followed by 33 respondents (20.8 per cent) who stated that they had given incentives to nurses. Surprisingly, 21 (13.2%), 20 (12.6%), 16 (10%), and 4 (2.5%) of respondents reported paying for IPC Materials, beds, Malaria tests, and COVID-19 vaccines, respectively. According to the data, respondents are being asked to pay for services that health care providers are supposed to provide for free.



SECTION 7:

Conclusion and Route to Reform

Conclusion and Route to Reform

The research encountered numerous obstacles, including the refusal of health care professionals to speak with data collectors. In one district, for instance, the Medical Superintendent in charge of primary health care and the District Medical Officer forwarded data collectors to each other for answers to study questions. Three days passed until the Hospital Secretary agreed to speak with the researchers instead. This demonstrates that openness, transparency, and accountability continue to be significant concerns in the healthcare industry.

The following are the suggestions made by the survey's participants for the future of the health sector:

Government

Salaries for health workers have risen since the FHCI's founding. However, these wage increases are insufficient to entice health personnel to relocate to Sierra Leone's poorest communities. Pay increases are consequently critical, especially in light of the current economic downturn, to deter and limit corruption.

The government will implement a performance-based financing system in collaboration with District Health Management Teams to offer resources and incentives to increase healthcare coverage and quality.

The Ministry of Health and its partners will ensure adequate monitoring of healthcare delivery systems, including the supply and use of pharmaceuticals and equipment. To ensure the timely disbursement of budgetary allocations to the MoHS, the MoF and partners must assess the systems and processes involved in the procurement, delivery, and distribution of medications and medical supplies. Respondents advised that, despite government resource limits, more health care staff in the primary and secondary health care systems be recruited.

Medical professionals and nurses receive clinical

training rather than public health training. In terms of nurses, some experts believe that community health nurses can handle up to two-thirds of Africa's illness load. Nonetheless, Sierra Leone continues to prioritize professional, degree-level nurses and State registered nurses, which take 3 to 4 years and is costly, above community health nurses (State enrolled Community Health nurses), which take 2 years and are less expensive. It is critical to reinstate community health nurse training. Respondents indicated that, while the government has given ambulances, roads be built and/or rebuilt to improve people's timely access to health care facilities in remote areas. The ambulances must be serviced regularly, and fuel must be given.

There is a significant disparity between human remuneration and goods and services. To ensure that money is available for the procurement of goods and services, the government should establish an imbalance between expenditure on salaries and spending on products and services.

There are numerous inefficient health care institutions. The government should seek to eliminate inefficiencies by requiring district health facilities to make decisions based on outcomes and inputs used. One approach could be to implement a performance-based contracting structure that will grant financing to DHMTs based on measurable results.

Civil Society

According to the National Health Accounts, 70% of out-of-pocket payments are spent on healthcare. There is a need for civic society to do research to determine current expenditure and the impact of the FHCI on the poorest households.

Among the 230 individuals polled, 122 (or 53 per cent) said they don't know whether regular folks are involved in decision-making. However, 82 of the respondents (35.7 per cent) stated that residents are active in healthcare decision-making in their community. In response

to this question, 26 respondents (11.3 per cent) responded that they are unaware. The respondents who said they didn't know and those who said no accounted for more than 60% of those polled. **Citizens' non-participation appears to be minor, leaving the possibility for abuse by those in power. Promoting civic responsibility requires advocating for citizens' engagement in healthcare decision-making.**

Civil societies design projects that effectively prioritize healthcare sector monitoring; civil societies guarantee that their subsequent programs include projects to promote public education on health accountability and transparency. The survey data revealed a knowledge gap among respondents regarding who primarily funds government health facilities in their community and how such resources are allocated. Of the 231 respondents, over 170 (73%) answered that they did not know who funded their community's health institution. On the other hand, around 61 of the respondents, or approximately 26.4 per cent, responded in the affirmative. This report is concerning because it is possible that it is to blame for patients being exploited by caregivers. This issue will be resolved or mitigated if impediments to transparency in healthcare funding are removed and beneficiaries are involved in decision-making and management of healthcare facilities.

Civil society should continue to advocate for the GoSL to boost its budgetary contribution to the MoHS to meet the Abuja criterion of 15% of the country's annual total budget, and to ensure that every penny provided is spent appropriately.

Due to an unsustainable reliance on donor money, there is little or no spending dedicated to communicable diseases, which are leading sources of morbidity and mortality. Partners should be able to advocate for funding for this area.

Due to ineffective fiduciary management systems at the district level, partner action is required to

strengthen the capacity of DHMT procurement and accounting staff to successfully manage the budget.

Private Sector

Some doctors and nurses work as full-time private practitioners. Others with formal government or non-governmental organization employment may engage in part-time private practice. Private practitioners are found country-wide and mostly provide services for the affluent who can meet their costs. Some are organized as large poly-clinics, where the doctors may have some specialist surgical or other skills. Private sector investment in the health sector, especially in rural areas, is the key to ameliorating the long-term effect of the inaccessibility of citizens to health care.

There are few research institutions in Sierra Leone. Networking between researchers has been poor in Sierra Leone. Peer review opportunities are limited. Peer review meetings are almost nonexistent, and getting a paper published is hard, especially for authors who are trying to get their first paper published and don't work with people who are known internationally. There are few institutions undertaking research in health and health-related areas in Sierra Leone.

Most of these institutions are either donor or NGO driven, with interest limited to needs assessments or a review of their implementation strategies. The research work undertaken by NGOs and donors is mostly done by consultants, often expatriates, with little knowledge about the context of Sierra Leone. There is no national health research policy or strategic plan. This has resulted in duplication, research gaps, and wastage of the limited resources that could have been otherwise used wisely. **There are limited grants for the management of research at various institutions. There is therefore a need for private sector investment in health sector research.**

A person wearing a white lab coat, a white surgical mask, and a yellow headband is holding a handheld device. The background is a blurred outdoor scene with a body of water. The entire image is overlaid with a semi-transparent orange filter and a pattern of dark brown triangles. The word "Appendix" is written in a white, italicized serif font, underlined, on the left side of the image.

Appendix

Appendix

Structured Research Questionnaire for service users

The research aims to reveal the health sector's governance and accountability challenges in Sierra Leone. For this reason, the study will research this problem through this questionnaire and other available methods of data collection.

NOTE: The law of confidentiality applies to all information provided by the respondents. This means that the researcher will not pass your information on to a third party, except with your fullest authority or as required by the Confidentiality Law of Sierra Leone.

1. Name of District

2. Chiefdom

3. Gender of Respondent: Female Male

4. Respondent's Age Bracket:

Between 18 and 30 years

Between 31 and 45 years

Between 46 and 60 years

5. Have you visited a Government Health facility during the last two years? Yes No

6. If yes, did you get the required services from the health facility? Yes No

If No, why

7. Did Health care workers - doctors and nurses treated you right during your visit?

Yes No

8. Were the health centres equipped to effectively manage the individual cases reported?

9. If No, how did they respond to the cases they received?

Appendix

10. Which category of patients did you belong to at the time of the visit?

- a. Under five
- b. Lactating mother
- c. Pregnant woman
- d. PLWD
- e. other categories

11. Did you pay any money for the services rendered to you? Yes No

12. If Yes, Please mention the amount of money spent.

13. Provide general feedback on the way the health facility is run and how the health care services are delivered.

14. What do you pay for among the following in the health facility? Please tick all the options that apply.

- a. Drugs
- b. Doctor's consultation fee
- c. Incentive to Nurses
- d. IPC materials (gloves, soap, hand sanitisers, bed nets)
- e. malaria tests
- f. ambulance fee

15. Is there a dedicated team of senior officers with the sole responsibility to monitor the work of the health facility?

Yes No

16. If the above answer is Yes, Please provide details of the supervisory and monitoring team and how they carry out their work.

Appendix

17. If the answer is No, Please state how the health facility is monitored.

18. What were the barriers to effective health care delivery in the facility?

19. How did you overcome these barriers?

References



References

1. Ministry of Health and Sanitation Sierra Leone, Directorate of Planning, Policy & Information (DPPI). Sierra Leone Health PER DPPI Input (Draft). April 2020.
2. Ministry of Health and Sanitation Sierra Leone. 2017. Sierra Leone National Reproductive, Maternal, New-born Child and Adolescent Health Strategy 2017–2021. Freetown.
3. Ministry of Health and Sanitation Sierra Leone. 2021 (draft). Sierra Leone National Health Sector Strategic Plan 2021—2025. Freetown.
4. Ministry of Health and Sanitation Sierra Leone. 2018. Summary Report of the 2017 SARA Plus in Sierra Leone: Service Availability and Readiness Assessment (SARA), Quality of Care Survey, and Data Quality Review.
5. Ministry of Health and Sanitation Sierra Leone. 2015. Sierra Leone Basic package of Essential Services, 2015–2020. Freetown.
6. Focus Group Discussions with Primary Health Care Givers 26th March -9th April 2022
7. Interviews with District Health Management Teams: Kailahun, Kenema, Kono, Bo, Port Loko, Bombali, Karene, Moyamba, Western Area 26th March - 9th April 2022.
8. Sierra Leone Demographic Health Survey, 2008
9. SLPP Manifesto 2018
10. World Bank. 2019. Technical Efficiency of Health Facilities in Sierra Leone: A Data Envelopment Analysis.
11. World Bank. World Development Indicators (WDI). 2021 Available <https://datacatalog.worldbank.org/dataset/world-development-indicators>. Accessed April 13, 2021.
12. Awoko Newspaper, September 2021
14. National Health Sector Strategic Plan 2017-2021
15. National Health Assessment Report, 2007
16. Sierra Leone Human Resource for Health Strategic Plan 2017-2021
17. Sierra Leone Universal Health Coverage 2022

