GOVERNMENT OF SIERRA LEONE

Ministry of Health and Sanitation

UNIVERSAL HEALTH COVERAGE ROADMAP FOR SIERRA LEONE 2021–2030

Table of Contents

FOREWORD

For Sierra Leoneans, the concept of Universal Health Coverage (UHC) has been translated into "All people in Sierra Leone having access to affordable quality health care services and health security without suffering undue financial hardship."

This Universal Health Coverage Roadmap for Sierra Leone is anchored in the National Health Policy (2021–2030) and defines the pathway to achieving quality and accessible health care for all, without anyone suffering financial hardship. The document clearly sets out broad strategies and the actions needed to improve health care delivery and access for all in Sierra Leone, using both international and locally attuned benchmarks.

In our country's quest for UHC, we have approached and developed this Roadmap reflecting the United Nations Sustainable Development Goal (SDG) 3.8, the solemn promise for a global call to action, and the Political Declaration of the High-Level Meeting on Universal Health Coverage adopted at the United Nations General Assembly in September 2019. The Roadmap also takes into consideration the report on the June 2019 scoping mission led by the World Health Organization (WHO), which identified, among other elements, several bottlenecks in our health system.

Strategic actions to address the findings of the WHO scoping mission, and the subsequent report on UHC readiness in two districts, Karene and Bonthe, were also reviewed and the findings of the report, especially those which highlighted weaknesses in the readiness to provide UHC, were compared to those of the scoping mission. The findings were then synchronized, before identification of the appropriate strategies on UHC. This comprehensive Roadmap is thus testament that the Government of Sierra Leone (GoSL) is committed to ensuring that the development aspirations of the citizens of Sierra Leone are met, using all means possible.

This Roadmap adopts the vision as defined in our National Health Policy (2021–2030) and outlines the change agenda to which the Government will commit in order to achieve this strategic vision for the next ten years.

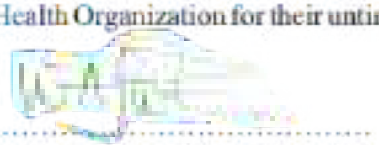
Final development of the Roadmap was prefaced by a series of meetings and consultations with internal Ministry of Health and Sanitation (MOHS) directorates, programmes and units. Meetings, consultations and in-depth discussions with international health development partners were also held with, inter alia, implementing partners and donors, local authorities such as paramount chiefs, parliamentarians, civil society activists, market women and men, academics and various government ministries, departments and agencies (MDAs). These broad-based engagements were pursued in order to facilitate inclusiveness and participatory decision-making, thereby ensuring that all relevant voices were heard and are reflected in this UHC Roadmap document aiming to steer the way on health care delivery and access for the coming decade.

This Roadmap has adapted the six WHO-prescribed health system building blocks, while ensuring the prominence of quality of care, and health security and emergencies, alongside a focus on community engagement, as recent health crises and emergencies have taught us the need to fully engage communities in tackling health problems.

The Universal Health Coverage Roadmap is a unique document as it is the very first of its kind, clearly outlining how the nation should achieve UHC to ease the financial burden of accessing health care. This Roadmap recommends using social health insurance as one sure means of achieving UHC: a trajectory which the Government is already pursuing in its addressing of quality health care access gaps. I would encourage everyone to not only read this Roadmap but to also support government efforts, as prescribed herein, to achieve UHC.

This Roadmap will create an enabling environment for delivering on SDGs, while synergizing efforts to deliver the 2030 health agenda for the benefit of all people in Sierra Leone.

On behalf of the Ministry of Health and Sanitation, I wish to extend my sincere appreciation to the Foreign & Commonwealth Development Office, the United Nations Children's Fund (UNICEF) and the World Health Organization for their untiring efforts to ensure we achieve UHC for all Sierra Leoneans.



Hon. Prof. Alpha T. Wurie
Minister of Health and Sanitation

ACKNOWLEDGEMENTS

The Ministry of Health and Sanitation wishes to acknowledge the contribution of various people, units, departments, directorates and institutions, whose individual and collective efforts have culminated in the present UHC Roadmap document.

Our appreciation goes to the Honourable Minister of Health and Sanitation, Prof. Alpha T. Wurie, whose visionary leadership and insistence on laying down a clear pathway to achieving UHC has energized the team of experts producing this document to achieve this feat in a timely manner.

Our thanks and appreciation go to WHO and UNCEF, our key partners, who have provided both funds and technical support for the production of this document.

Development of the UHC Roadmap would have been almost impossible without the direction of key Ministry of Health and Sanitation Directors. We are therefore grateful to Dr. Francis Smart, who led the process, Dr. Donald Bash-Taqi, Matron Mary Fullah, Prof. Dr. Mohammed Samai, Dr. Sartie Kenneh, Dr. Alie Wurie, Dr. Matthew Vandy, Dr. Mohammed Vandi, Dr. Momodu Sesay, Dr. Samuel Smith and Mr. Emile Koroma.

The development of the Roadmap could not have been executed without the individual and collective coordinated efforts of the Technical Working Group. We are particularly grateful to Mrs. Emmanuella Anderson, who coordinated the entire process. We also extend our sincere gratitude to the following people within the Working Group for their technical inputs: Mr. Royston Wright, Dr. D'Ameilda Selassie, Mrs. Penny Walker-Robertson, Dr. Janet Kayita, Ms. Yuki Suehiro, Dr. Hailemariam Legesse, Dr. Asha Pun, Mr. Kofi Amponsah, Ms. Kazumi Iden, Mr. Paul Sengeh, Mr. Momoh Jimmy, Dr. Edward Magbity, Dr. Michael Amara, Mr. Edward Foday, Mr. Mohamed Dumbuya, Mr. Gerald Thomas, Dr. Alphajoh Cham, Dr. Tom Sesay, Dr. Francis Moses, Matron Margaret Mannah, Dr. Zikan Koroma, Mrs. Doris Harding and Dr. Luc Geysels.

Special thanks go to Dr. Koku Awoonor, whose technical leadership culminated in the drafting and finalization of this Roadmap. We also want to particularly recognize the role of the following District Medical Officers and District Superintendents: Dr. Roland Marsh, Dr. Donald Grant, Dr. Prince Masuba, Dr. Foday Sesay, Dr. Osaio Kamara, Dr. Steven Sevalie, Dr. Ibrahim Sayo, Dr. Valerie John and Dr. Sylvia Fasuluku.

It is impossible to mention here each contributor by name, but rest assured that we are very grateful for your invaluable input. We express our gratitude to the Paramount Chiefs, Representatives from Local Councils, Market Women, Youth Groups, the Disability Commission and Civil Society Organizations, whose views, during our consultations, have been synchronized into this Roadmap. The MOHS is grateful to all those partners and individuals who contributed to the development of the UHC Roadmap, but whose names have been omitted. We thank you all.

.....

Rev. Can. Dr. T. T. Samba

Chief Medical Officer
Ministry of Health and Sanitation

ACRONYMS & ABBREVIATIONS

BPEHS	Basic Package of Essential Health Services
CHW	Community Health Worker
COVID-19	Coronavirus Disease 2019
DHMT	District Health Management Team
DPPI	Directorate of Policy, Planning and Information
EHSP	Essential Health Services Package
FHCI	Free Health Care Initiative
GoSL	Government of Sierra Leone
HCW	Health Care Worker
HDP	Health Development Partner
HMIS	Health Management Information System
HRH	Human Resources for Health
ICT	Information Communication Technology
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
MOHS	Ministry of Health and Sanitation
MTNDP	Medium-Term National Development Plan
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NHP	National Health Policy
NHSSP	National Health Sector Strategic Plan
PHC	Primary Health Care
PHU	Peripheral Health Unit
RF	Results Framework
RMNCAH	Reproductive, Maternal, New-born, Child and Adolescent Health
SDG	Sustainable Development Goal
SLA	Service Level Agreement
SLeSHI	Sierra Leone Social Health Insurance
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WHO-AFRO	World Health Organization Regional Office for Africa

GLOSSARY

Catastrophic Spending on Health	Out Of Pocket Spending (without reimbursement by a third party) exceeding a household's ability to pay.
Impoverishing Spending on Health	When a household is forced by an adverse health event to divert spending away from non-medical budget items, such as food, shelter and clothing, to such an extent that spending on these items is reduced below the level indicated by the poverty line.
Out Of Pocket Spending	Payment borne by the individual or household (often in cash, at the point of service) which are not subsequently reimbursed by the government or an insurer; they constitute the most inequitable form of health spending.
Quality of Care	The extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve these outcomes, health care must be safe, effective, timely, efficient, equitable and people-centred.
Social Mobilization in Health	The process of bringing together all societal and personal influences to raise awareness of and demand for health care, assist in the delivery of resources and services, and cultivate sustainable individual and community involvement. In order to employ this form of social mobilization, members of institutions, community partners and organizations, and other actors collaborate to reach specific groups of people for intentional dialogue.
Social Protection	Measures for the prevention and reduction of risks that threaten the socio-economic well-being of individuals, households and society as a whole.
Universal Health Coverage (UHC)	All people and communities are able to use the promotive, preventive, curative, rehabilitative and palliative health services they need, which are of sufficient quality to be effective, while the use of these services does not expose the user to financial hardship.
Universal Health Coverage Roadmap	Overview of projects under the Universal Health Coverage Strategy; describes concrete project goals, objectives and deliverables within a coherent framework; contains milestones and timelines; outlines risks and dependencies.
Universal Health Coverage Strategy	A country's high-level plan to achieve Universal Health Coverage; incorporates other specific strategies (human resources, health financing, etc.).

1 BACKGROUND

1.1 Introduction

The provision of equitable access to quality and affordable health care for all without undue financial hardship to achieve Universal Health Coverage, as defined in target 3.8 of the SDGs, is now a national priority for many low- and middle-income countries. For this reason, an increasing number of countries are currently in the process of expanding health coverage and uptake among their population, particularly people working in the informal sector and other vulnerable groups, and providing financial protection. Since there is no one-size-fits-all approach to providing health care for all, each country must develop its own unique strategy, approaches and tools for achieving UHC.

In Sierra Leone, despite the importance attached by policymakers and health managers to efforts to improve quality of health care, significant deficits persist in accessing quality health care, and this is anticipated to compromise efforts towards the UHC goal. The 2017 Global Monitoring Report on UHC estimates that Sierra Leone had a service coverage index of 36% in 2015, with 10.42% of the population facing catastrophic out-of-pocket spending on health.[1]

The Government has adopted progressive policies and measures to lower or eliminate user charges and improve financial protection in order to increase both service coverage and uptake. A myriad of policy frameworks have been developed to improve population health outcomes, including, but not limited to: the Medium-Term National Development Plan (MTNDP) 2019–2023; the Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH) Policy/Strategy 2017–2021; the National Community Health Worker Policy 2016–2020; the Multisectoral Malnutrition Reduction Strategic Plan 2019–2025; the Sierra Leone Every New-born Action Plan 2017–2030; the Water, Sanitation and Hygiene (WASH) Programme; the Human Resources for Health (HRH) Policy 2017–2021; the HRH Strategy 2017–2021; the Basic Package of Essential Health Services (BPEHS) 2015–2020; and the National Action Plan for Health Security 2018–2022. These various policies, strategic/action plans and guidelines are operational within the health sector and together play a synergetic role in achieving UHC.

In fulfilment of the MTNDP goal of enhancing human capital development to achieve middle-income status by 2039, the GoSL has embarked on comprehensive health sector reform, aimed at transforming the under-resourced health sector into a technologically integrated and functioning national health care delivery system that is both fit for purpose and guarantees universal access and coverage. The vision of the present UHC Roadmap is aligned with that of the new National Health Policy (NHP) and the National Health Sector Strategic Plan (NHSSP) for UHC. Thus, the development of this Roadmap serves as the framework for guiding the reform process.

1.2 Purpose and Scope of the Roadmap

This UHC Roadmap is intended to support the Government in the planning process directed at progressive realization of UHC. The GoSL has envisaged a roadmap that describes the pathway of the health reform processes required to achieve universal access to quality health care services (including prevention,

[1] World Health Organization/The World Bank, *Tracking Universal Health Coverage: 2017 Global Monitoring Report*, 2017, <http://pubdocs.worldbank.org/en/193371513169798347/2017-global-monitoring-report.pdf>, accessed 20 November 2018.

promotion, treatment and rehabilitation), based on the three dimensions of access laid down by WHO: physical accessibility, financial affordability, and acceptability. With a focus on the entire population and the whole health system, the Roadmap seeks to:

a) Identify the challenges and gaps which clients and patients face in accessing health care;
b) Outline the necessary steps towards coherent and effective design of the feasible pathway, taking into consideration the political and socio-economic context, the current state of the health care system, and stakeholder preferences;
c) Propose how to address all health system building blocks and design elements appropriate to the context of Sierra Leone;
d) Provide concise descriptions of the priority intervention actions and milestones indicating progress towards set goals; and
e) Ensure processes are aligned with other relevant national priorities, strategies and polices, and that risk mitigation is adopted as appropriate.

This Roadmap adopts the vision as defined in the NHP 2021–2030 and outlines the change agenda to which the Government will commit in order to achieve the strategic vision for the next ten years. The NHSSP 2021–2025 and the results-based Monitoring and Evaluation Framework are developed on the basis of this UHC Roadmap, which sets out the priority interventions for investment and resource mobilization for the next ten years in the health sector at large.

1.3 Planning Process

At the launch of the regional 'flagship programme' by the Regional Director of the World Health Organization Regional Office for Africa (WHO-AFRO) to operationalize the UHC Actions Framework, Sierra Leone made a specific request for Technical Assistance. The resulting scoping mission took place in June 2019. The mission findings identified, among other elements, several bottlenecks impeding the country's progress towards UHC. A nine-day intensive workshop with directors, programme managers, district health management teams (DHMTs) and health development partners (HDPs) was also held, wherein strategies were determined to address the bottlenecks identified.

Moreover, the report on UHC readiness assessment in two districts, Karene and Bonthe (Dibia and Sogbini Chiefdoms, respectively) was also reviewed, and the findings, especially those highlighting weaknesses in the readiness to provide UHC, were compared to those of the scoping mission, before identifying the appropriate strategies for achieving UHC. In addition, the Ouagadougou Declaration on Primary Health Care and Health Systems and the framework for implementation, the Astana Declaration, and the Cotonou Declaration, among other documents, were carefully reviewed to inform the process.

A comprehensive desk review was undertaken to identify all materials necessary to take into consideration when developing Sierra Leone's UHC Roadmap.

1.4 Structure of the Roadmap

The UHC Roadmap is structured into five sections and includes various annexes. The first section is an introductory background outlining the rationale and purpose of the Roadmap, and the efforts towards achieving UHC undertaken thus far. The next section considers the policy direction encompassing the

context and the guiding principles. Following that appears a section on the context of Primary Health Care (PHC), outlining strengths and opportunities, challenges, and a possible way forward. Treatment of the priority interventions areas constitutes the fourth section, which emphasizes how each of the interventions plays a significant role in contributing towards achieving UHC. The fifth section of the UHC Roadmap, on rolling out the Roadmap, provides explicit details on implementation of this document, measuring performance, monitoring and evaluation (M&E), and the proposed results framework (RF), including selected indicator areas to monitor progress on UHC implementation and the corrective actions necessary for the success of UHC in Sierra Leone. The annexes attached to this UHC Roadmap outline recommended areas and issues considered during review of the NHP and the NHSSP; this final section of the Roadmap also presents the implementation framework for the UHC Roadmap.

1.5 Theory of Change

The process for achieving UHC in Sierra Leone depends largely on the performance of the peripheral health units (PHUs). This level of services is the focus of PHC and requires effective strengthening if UHC is to be achieved. This theory of change therefore reflects the strategic shift of investing in the appropriate strategic pillars areas to achieve the necessary targets as shown in Figure 1. The depicted theory of change explains how activities of strategic pillars are understood to bring about the desired results and contribute to achieving impact. The theory of change is a summary of the entire focus of the UHC Roadmap design, predicated on strategic priority pillars, while detailed information is found in the various sections of the Roadmap and particularly as Strategic Commitments.

Figure 1: Theory of Change – Achieving UHC through Health System Strengthening

Source: Directorate of Policy, Planning and Information (DPPI) (MOHS, 2020)

2 CONTEXTUAL ANALYSIS OF THE HEALTH CARE SYSTEM

2.1 Overview of the Health Care System

Sierra Leone has a three-tier, pyramidal health care system structured into tertiary level, secondary level, and primary level (Figure 2). The health system comprises a network of 1,411 public and private health facilities, including 54 hospitals and 70 nursing and surgical clinics. The country has a health facility density of 1.8 facilities per 10,000 population.[2] The scope and range of services provided at each level is defined by the BPEHS 2015–2020.[3] The top tier (tertiary) of health facilities operate as the country's specialized referral hospitals, managing complex health problems and engaging in teaching and research.[4]

The second tier (secondary) comprises district/regional hospitals entrusted with the responsibility to provide the secondary level of health care services, especially as a referral point for primary care facilities, which include: comprehensive emergency obstetric and new-born care; treatment of severe childhood diseases, including severe acute malnutrition with complications, diagnosis, and treatment of malaria; clinical management of non-communicable disease (NCD); laboratory and pharmacy services; diagnostic imaging; blood services; and surgery. The MOHS is currently in the process of upgrading regional hospitals with additional specialized care units, to which district hospitals will refer complicated cases before moving to tertiary care.

The primary tier is headed by the DHMTs, and provide primary care services for the local population within the respective catchment areas. PHUs make up the primary care facilities, and are functionally defined at three levels, with specified building types, equipment, drug supplies and staffing needs[5]: community health centres, community health posts and maternal and child health posts – in ascending order of level of care. A range of preventive and basic curative services are also delivered directly at the community level (outside of health facilities, but with linkages to PHUs through supervision, reporting, and supply chain management).

Increasing fragmentation continues to challenge the efficiency and coherence of health service delivery in Sierra Leone, impeding strengthening and emergency response capabilities. This fragmentation is in evidence across governance structures, strategic policy and planning processes, funding mechanisms, medical supply chain systems, external actor engagement, and community engagement interventions.[6] This

---

[2] Ministry of Health and Sanitation, *Summary Report of the 2017 SARA Plus in Sierra Leone: Service Availability and Readiness (SARA), Quality of Care, Data Quality Review*, Freetown, 2018, <https://mohs2017.files.wordpress.com/2018/05/mohs-sierra-leone_sara-report_final.pdf >, accessed 15 September 2020.

[3] Ibid., *Sierra Leone Basic Package of Essential Health Services, 2015–2020*, Freetown, 2015, <https://mohs2017.files.wordpress.com/2017/06/gosl_2015_basic-package-of-essential-health-services-2015-2020.pdf>, accessed 15 September 2020.

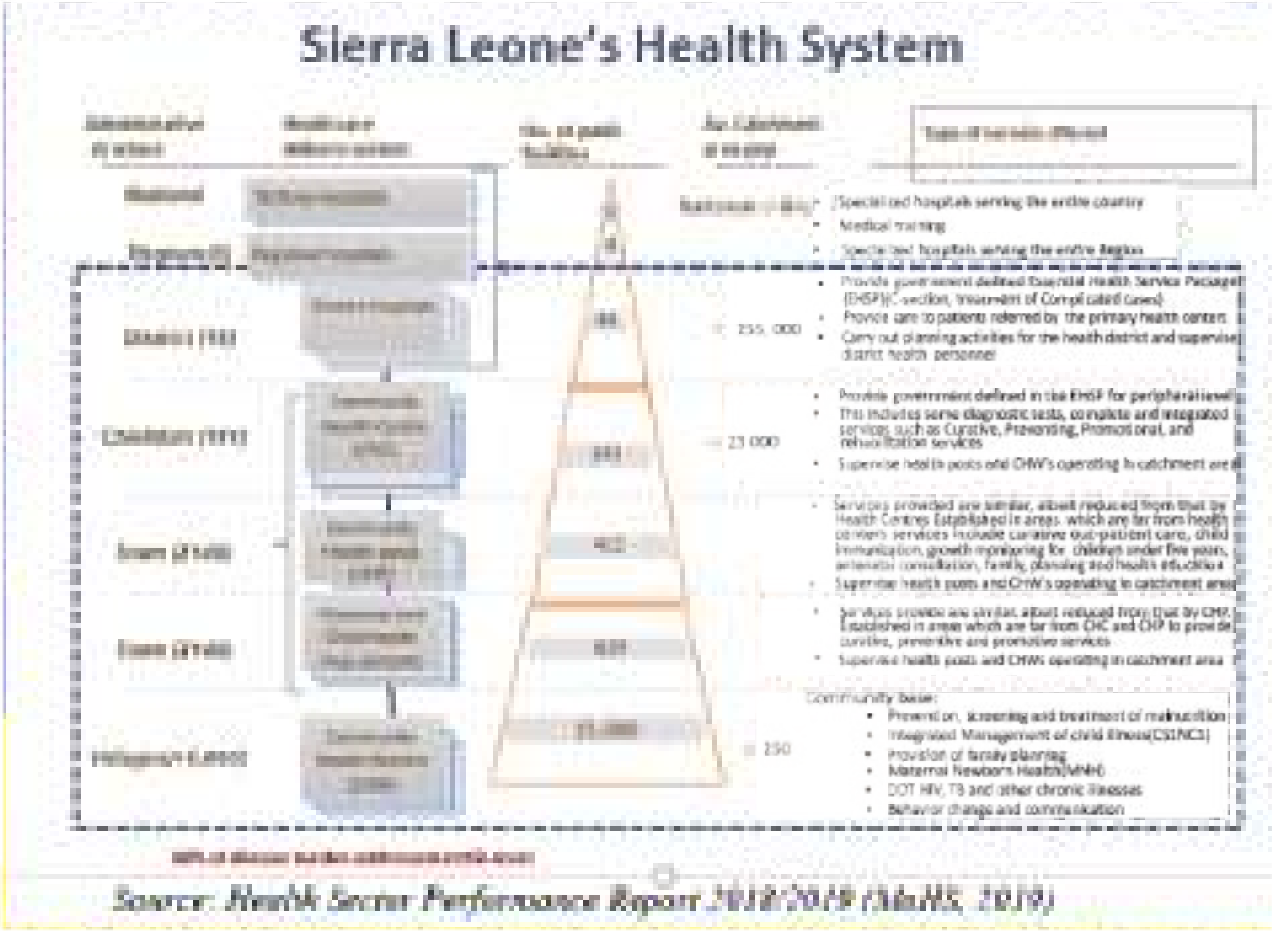
[4] Ibid., *National Health Sector Strategic Plan, 2017–2021*, Freetown, 2017, <https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/sierra_leone/sierra_leone_nhssp_2017-21_final_sept2017.pdf>, accessed 15 September 2020.

[5] Community Health Officers head the community health centres; Community Health Assistants head the community health posts; and Maternal and Child Health Assistants head the maternal and child health posts.

[6] Barr, Arwin et al., 'Health sector fragmentation: three examples from Sierra Leone', *Globalization and Health*, vol. 15, no. 1, December 2019, article 8, <https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-018-0447-5accessed>, accessed 15 September 2020.

fractured dynamic in turn contributes to duplication of services, dilution, distortion and diversion of limited human and financial resources into overlapping or inadequately integrated vertical disease programmes, and weak coordination and integration between levels of care, resulting in poor health outcomes.[7] Further, the over-reliance on external investment and weak coordination of such investment and technical assistance perpetuates the fragmentation, undermining sustainability within the health sector.

Figure 2: Structure of the Health Care System



Source: Health Sector Performance Report 2018/2019 (MoHS, 2019)

The Government introduced the Service Level Agreements (SLAs) to strengthen the coordination, integration, monitoring and governance of health sector activities and global health initiatives. However, fragmentation, overlapping roles and responsibilities of local governing bodies, and inconsistent devolution of authority to DHMTs have all undermined the initiative, contributing to administrative inefficiencies and poor health outcomes. Fragmentation could be reduced by promoting harmonization of priorities and programmes through strategic policy and planning; commitment of external actors to strengthening national health systems and governance structures; and greater accountability and trust in collaborative partnership.

There is a need for strengthened information systems to adequately track progress on the implementation and monitoring of health care programmes under the UHC Roadmap. One challenge observed in relation

[7] Adwok, John, Kearns, Ellen H. and Bryan Nyary, 'Fragmentation of Health Care Delivery Services in Africa: Responsible Roles of Financial Donors and Project Implementers'. *Developing Country Studies*, vol. 3, no. 5, May 2013, pp. 92–96, <https://iiste.org/Journals/index.php/DCS/article/view/5501/5616>, accessed 15 September 2020.

to the existing national health management information system (HMIS) is the poor quality of routine reports from health facilities and districts, which often tend to be incomplete, overdue, inconsistent, or subject to bias. It is imperative to systematically improve the quality of facility generated data through a well-functioning and integrated HMIS, complemented by systematic and periodic facility assessment of service availability and readiness, and to record review of selected indicators – so as to fill data gaps and verify the quality of routinely reported data.

2.3 Health Service Coverage

The path towards UHC is a continuous process that responds to changes in shifting demographic, epidemiological, technological and socio-economic and political trends. The primary aim of the health service coverage dimension of UHC is to ensure that individuals in need of promotive, preventive, curative, rehabilitative or palliative health services receive such services, and that the quality of services received is adequate to provide the desired health gain. For many years, Sierra Leone has made its PHC system the key vehicle for improving essential health services coverage.

2.2.1 The Primary Health Care System

Available evidence globally confirms that a strong PHC system is associated with improved population health outcomes and equity, appropriate service utilization, user satisfaction, cost efficiency and resilience. Thus, recognizing and catalysing PHC and making it accessible and fully functional constitutes a cornerstone for achieving UHC. Strong PHC systems are needed to provide continuous, comprehensive, integrated and co-ordinated care for the whole population. In realization of this, the Government, in 2010, strengthened the PHC system to implement the Free Health Care Initiative (FHCI). With the FHCI, and the introduction of the BPEHS 2015–2020, public demand for and uptake of health care services have increased, which in turn has increased pressure on the public budget. The sustainability strategy should therefore include reduction of the burden on secondary and tertiary care by strengthening primary and community care, which accounts for 80% of those seeking treatment. The emphasis on prevention and promotion, proximity to people, and people-centred services – and thus high levels of acceptance among the population – are some of the benefits of PHC. This dynamic is particularly relevant to the Sierra Leone context, where many of the premature deaths which occur can be averted through evidence-based, cost-effective (and simple) interventions.

The importance of PHC is underpinned by the Alma Ata Declaration (1978) and the recent Astana Declaration on Primary Health Care (2018), alongside the Health for All by 2000 approved in the 1980s, the Political Declaration of the High-Level Meeting on Universal Health Coverage, and the Medium-Term National Development Plan 2019–2023. In Sierra Leone, PHC is therefore perceived as the foundation for strengthening health systems to accelerate progress towards UHC. The recommended priority areas of the Ouagadougou Declaration for Primary Health Care and Health Systems have, alongside other inputs, served as the basis for developing the present UHC Roadmap.

Several challenges undermine the effectiveness of the PHC delivery system. The decentralization process has not been fully implemented, and human and other resource capacities at district and local levels remain weak or absent. PHC facilities lack the required capacity to provide essential health services (infrastructure, power, WASH facilities, laboratories, equipment, skilled human resources, drugs and commodities,

digitalization, etc.). HRH are limited in numbers and reflect a poor skill mix, with unpaid volunteers still comprising a significant proportion of total health workforce. The negative impacts of low numbers and distribution of HRH is felt more at the PHC levels.

Other challenges include low quality of care, irrational use of essential medicines (especially antibiotics), weak linkage between community health workers (CHWs) and PHUs. Limited availability, accessibility, quality and use of data for decision-making at all levels are also present, and must be addressed if an effective functioning system is to emerge. Special attention needs to be paid to community empowerment and engagement such that communities are able to conduct self-assessment and identify their own gaps and find appropriate solutions. Currently, the majority of the existing community structures, the Village Development Committee and the Facility Management Committee, are not fully functional – and there is no community feedback mechanism on health services availability or quality.

There are several strengths and opportunities associated with embedding PHC as the backbone for achieving UHC in Sierra Leone. These strengths and opportunities include, but are not limited to, the political commitment and favourable policy environment for UHC and SDGs. The involvement of political leadership will drastically enhance fruition of several activities aimed toward achieving UHC. During the World Health Assembly in May 2019, the Hon. Minister of Health and Sanitation had an audience with the WHO Director-General focused on UHC. In September 2019, at the United Nations General Assembly, His Excellency the President of the Republic of Sierra Leone pledged strong political commitment to ensuring UHC is achieved in both Sierra Leone and on the African continent at large. In this regard, there are already clearly defined local governance structures with decentralized PHC, in addition to community structures for facilitating community ownership and propelling commitment of the required resources towards UHC implementation.

Alongside these developments, there is also now in place a defined service delivery system from village/community level to the tertiary level, which can be leveraged for all PHC activities. The FHCI with its gradually increasing government contribution represents a strong foundation for realizing the financial risk component of UHC. Furthermore, the PHC Operational Handbook has been updated to accurately reflect the current PHC service delivery system. However, there remains a need to streamline the delivery model from the perspective of efficiency, effectiveness and equity, and this will subsequently increase equitable access to PHC services. Ongoing recruitment and training of specialized HRH at PHC level represent strengths and opportunities to leverage in achieving UHC. Strengthening the coordination and collaboration between the MOHS and the Ministry of Local Government and Rural Development could also facilitate community participation and engagement, establishing an effective social accountability process. Several strong partnerships have already been established within the health system, between non-governmental organizations (NGOs), CSOs, and development partners and the PHC decentralized structures, which will provide strong support for UHC implementation. It should be noted, however, that the partnership structures do need to be strengthened in order to remain viable and functional within the context of UHC.

The Government of Sierra Leone commits to strengthening the health system by increased investment in PHC through enhancing capacity and infrastructure development. PHC warrants such extensive strengthening as it is the first point of contact with the health services – prioritizing cost-effective essential

public health functions with a focus on health prevention and promotion. The PHC system will provide a comprehensive range of services and care, including (but not limited to): immunization screening; prevention, control and management of non-communicable and communicable diseases; care and services that promote, maintain and improve maternal, new-born, child and adolescent health and nutrition; mental health services; and services directed toward sexual and reproductive health and rights. Sustainable PHC will bring an immense range of benefits, while enhancing health system resilience to prevent, detect and respond to infectious diseases and outbreaks. As such, in line with the UHC Political Declaration, the Government commits to increasing the domestic resource allocation to PHC by at least 0.6 percent of GDP annually.[8] As implementation of the CHWs policy and other community engagement programmes are highly donor dependent, there is also a need for the GoSL to increase domestic resource mobilization to support these programmes.

2.2.2 The Tertiary and Secondary Health Care Systems

While making Primary Health Care the vehicle for achieving UHC, the GoSL recognizes that it is necessary to ensure effective interaction between primary, secondary and tertiary care in order to deliver the best services to patients and communities. Making a choice between primary and secondary care has not been part of the decision-making process, rather this process has centred on recognizing and adequately supporting the unique attributes and skillsets offered by each system. In instances where the focus has been placed on secondary and tertiary care, the crucial role of PHC in cost-effective UHC has not been underestimated. For UHC to be achieved, Sierra Leone therefore needs a lead PHC system that closely interacts and coordinates with both the secondary and tertiary systems. In this regard, sector leadership and commitment are needed to advocate for patients, ensure appropriate care, safety, and cost effectiveness, and support rational use of secondary care resources.

2.3 Financial Risk Protection

Many people in Sierra Leone suffer financial hardship when accessing required health care services. Globally, UHC interventions in the area of financial risk protection focus on two main areas: i) catastrophic spending on health; and ii) impoverishing spending on health.

In 2018, the National Health Accounts estimated that the total out-of-pocket (OOP) expenditure on health was Le 1.638 trillion, which amounts to 64.7% of total health expenditure, compared to an average of 34% for sub-Saharan Africa overall. Annual OOP health expenditure in Sierra Leone stands at approximately Le 246,000 per capita.

After funding from the national exchequer, foreign aid is the second largest source of health financing. Domestic public financing has contributed between 6 and 12 percent of total health financing over the past 10 years, increasing from 7 percent in 2014 to 11 percent in 2020.

Due to the high levels of out of-pocket spending as a percentage of current health expenditure and general government health expenditure as a percentage of gross domestic product the level of financial protection is low. Therefore, if deliberate steps are not taken to improve the situation, progress towards achieving

[8] Ministry of Finance, *Government Budget 2020*, Freetown, 2019, <https://mof.gov.sl/wp-content/uploads/2019/11/FY-2020-Budget-Speech-and-Profile-1.pdf>, accessed 15 September 2020.

financial protection for UHC will be limited. For this reason, if UHC is to be achieved, Sierra Leone needs to initiate reforms aimed at reducing OOP spending.

With out of-pocket spending as a percentage of current health expenditure estimated at higher than that for the Africa Region, Sierra Leoneans spent a higher proportion of their income on health than many of their regional counterparts.

2.4 Health System Performance Dimension

2.4.1 Equitable Access

Sierra Leone has an average of 1.8 health facilities per 10,000 population.[9] WHO recommends 2 facilities per 10,000 population. The health facility density is relatively high in Sierra Leone compared with other countries in the subregion, yet there are several hard-to-reach communities, in both urban and rural areas, and challenging riverine communities that need quality and comprehensive health care services. This Roadmap provides the mechanism to ensure that physical accessibility is improved, with appropriate and adequate HRH interventions to close the prevailing equity gaps, which will improve health outcomes.

2.4.2 Quality of Care

One of the major challenges the national health system contends with is poor quality of care as a result of resource constraints, which is propounded by the high of cost of care at service delivery points, especially in hard-to-reach communities. The MOHS has established its Quality of Care Programme, which is striving to redress this dynamic, and which will help embed UHC nationally. So as to reinforce the importance of quality of care, the MOHS has made this area one of the strategic pillars in the theory of change central to this UHC Roadmap, thereby ensuring that quality of care receives the necessary attention. Quality of care is further reflected as a priority focus in the UHC roadmap implementation and monitoring frameworks.

[9] Ministry of Health and Sanitation, Service Availability and Readiness Assessment (SARA) Report, 2017

3 STRATEGIC POLICY DIRECTION

3.1 Vision, Mission, Goal and Strategic Objective

3.1.1 Vision

All people in Sierra Leone have access to affordable quality health care services and health security without suffering undue financial hardship.

3.1.2 Mission

Building a resilient and responsive health system to provide and regulate comprehensive health care services in an equitable manner through innovative and appropriate technology and partnerships, while guaranteeing social and financial protections.

3.1.3 Goal

By 2030, all people in Sierra Leone enjoy equitable access to quality and affordable health services, whether public or private, at all times and without any undue financial hardship.

3.1.4 Strategic Objective

Transform the health sector from an under-resourced, ill-equipped and inadequate health care delivery system into an adequately resourced and functioning national delivery system that is affordable and accessible to all, especially the most vulnerable segment of the population.[10]

3.2 Guiding Principles and Strategies

In order to achieve the specific aims of this Roadmap, the following values will provide the underpinning base:

i. Country Ownership and Leadership: The Government and people of Sierra Leone shall set the agenda on how to attain UHC and all partners shall be encouraged to harmonize and align their programmes and activities in line with planned government priorities.

ii. Human Rights-based Approach and Equity: UHC shall be achieved with the aim of safeguarding access to meet the demand for health care among all people in Sierra Leone, especially vulnerable and deprived populations and those living in hard-to-reach areas, for the same high-quality health care, regardless of geographic location or socio-economic factors. This shall be achieved in tandem with protection of patient's rights.

iii. **Coordination and Collaboration**: Coordination and collaboration between and among all key stakeholders in the health sector to limit fragmentation and duplication shall be exercised. The health system of Sierra Leone shall be driven by the principle of '**One Policy, One Strategy and One M&E Plan**'.

[10] Government of Sierra Leone, *Medium-Term National Development Plan 2019–2023*, Freetown, 2019, <https://www.imf.org/en/Publications/CR/Issues/2019/07/09/Sierra-Leone-Economic-Development-Documents-National-Development-Plan-2019-23-47099>.

iv. **Mutual Accountability for Results:** Successful attainment of UHC entails that implementation of activities must be tied individually and mutually with all health sector actors involved in performance measurement and management and accountability, which will be central to achieving health targets.

v. **Value for Money:** Value for Money shall be a pivotal part of all transactions in the delivery of UHC, ensuring that limited resources go as far as possible. All stakeholders shall be expected to use available resources for health efficiently and effectively in the pursuit of maximum health gains. Opportunities shall be created to facilitate integration of health service delivery to leverage efficiency, effectiveness, and cost-benefit in addressing the health needs of people living in Sierra Leone.

vi. **Transparency and Accountability:** Regular and comprehensive stakeholder communication is critical for UHC success. This means that stakeholder consultations should be institutionalized, starting at the community level, with the public made aware of health reform issues. Resource holders should be held responsible and accountable for actions pursued under their stewardship, while the public will be kept informed on how health resources are being used.

vii. **Ethical Considerations:** The provision of health care and its related activities will be underpinned by public health ethical requirements of **respect** (confidentiality, people-centred), **beneficence** (safety and efficacy) and **justice** (fairness).

viii. **Sustainability:** Successful implementation of activities to achieve desirable targets through realistic planning, resource generation and allocation shall be central to the achievement of UHC.

ix. **Community Participation and Ownership:** Communities shall be well mobilized and empowered to exercise leadership in participation and ownership in addressing the health needs of their communities, and individuals empowered to be responsible for their own health. An environment that is conducive to enabling strengthened community capacity, thereby empowering communities to demand accountability from the holders of resources, shall be created.

x. **Financial Protection:** The population shall be protected from incurring financial burden when seeking health care.

Figure 3: Guiding Principles and Strategies

3.3 Strategic Direction

Sierra Leone is committed to accelerating the move towards UHC to ensure equitable access to quality health services for the entire population. The move towards progressive universal coverage will be made through the provision of basic health services, free of charge, to service recipients under the Free Health Care Initiative and other services under the BPEHS provided at an affordable cost through targeted subsidies. The current focus is on the enhancement and progressive expansion of the current BPEHS into the Essential Health Service Package (EHSP) for UHC within the framework of the Sierra Leone Social Health Insurance (SLeSHI) scheme. The EHSP will ensure continuous improvement in the quality of care being delivered, making services more affordable and covering the target population in need – especially the vulnerable and poor. The Health Financing Strategy currently being developed will identify and initiate suitable and sustainable options to finance the health sector and provide financial risk protection options for moving towards UHC.

The present Roadmap will propel the health sector's advancement towards UHC over the next 10 years, through 5 key strategic directions. While the latter four strategic directions will ultimately produce the desired outcomes, the first direction sets in place an important condition for achieving the aims of those directions:

1. Health system reforms for UHC
2. Equitable access to health services
3. Quality health services
4. Sustainable financing and financial protection
5. Health security

4 STRATEGIC PILLARS

The 5 key strategic directions translate into 10 strategic pillars which reflect higher-level commitments and timelines as derived from the UHC Scoping Mission Report. These activities will be detailed in the NHSSP for UHC 2021–2025, using a well-articulated logic model.

4.1 Health System Reform for UHC

The UHC Roadmap prioritizes good health governance to ensure clear lines of authority and decision-making, and to instil the understanding that all levels of the health system should be transparent, responsive and accountable, ultimately to the population they serve. Achieving the aspirations of UHC requires organizational structures and accountability mechanisms at both central and local levels to be strengthened alongside the requisite competencies in leadership and management. The UHC Roadmap focuses on further strengthening a decentralized PHC system to promote local health governance. Decentralized health planning and management inspires local leadership, mobilizes local resources and promotes innovation in addressing local health needs, leading to local ownership, which in turn results in more equitable and quality health services. The MOHS will strengthen its technical and management leadership, regulatory function, supervision and monitoring, policy development, resource mobilization, capacity building and infrastructure provided to local health units.

4.1.1 Strategic Pillar 1: Leadership and Governance

Strategic objective 1: Prioritize UHC as a commitment at all levels of action to improve health outcomes by 2030	
Strategic Commitments **We will:**	
a. Facilitate enactment of appropriate policies and legislations to manage both state and non-state actors in the health sector;	2021–2022
b. Strengthen existing platforms, establish and operationalize inter-ministerial bodies to coordinate laws, policies and practices that impact health outcomes for policy and institutional coherence;	2021–2021
c. Develop and effectively implement a NHSSP that employs UHC as the core strategic means to achieve its goal;	2021–2025
d. Advocate and support the decentralization process of fiscal and human resources to strengthen the PHC delivery model (Community Health Centres-Community Health Posts-Maternal and Child Health Posts-Community);	2021–2025
e. Restructure leadership and management across all levels of health care provision to champion high performing health systems;	2021–2025

f.	Strengthen national and subnational leadership and planning mechanisms and platforms for alignment with strategic objectives, and collaboration and coordination between HDPs;	2021–2025
g.	Improve coordination and integration of vertical programmes in the health system to minimize fragmentation across programmes;	2021–2025
h.	Involve all critical stakeholders in the SLA process through joint annual planning and review meetings;	2021–2026
i.	Establish inclusive social accountability mechanisms for all parts of the health system with strong engagement of local communities and civil society;	2021–2030
j.	Integrate and coordinate programme planning and review across all levels of the health system and government;	2023–2030
k.	Strengthen licensing, certification, and accreditation mechanisms for health practitioners with defined (established responsible) regulatory bodies;	2021–2026
l.	Revise the national policy and strategy on the use of traditional and complementary medicines;	2021–2022
m.	Develop a policy framework and legislation to ensure a balanced approach to private sector investment and the quality of health services;	2023–2023
n.	Establish a functional accreditation system of medical certificates for all persons living with disabilities	2021–2025

4.1.2 Strategic Pillar 2: Human Resources for Health

Strategic Objective 2: Attain a minimum density of 45 skilled health workers per 10,000 population[s] within a high performing workforce that is optimally distributed and delivering high-quality care services by 2030	
Strategic Commitments	**When**
We will:	
a. Establish a health workforce stabilization programme to ensure focused and coordinated investment in the health workforce;	2021–2030
b. Expand health workforce production capacity based on needs and demands;	2021–2030
c. Optimize health workforce distribution, retention and utilization for UHC;	2021–2030
d. Rationalize the number and deployment strategy of CHWs alongside review of the female to male ratio, level of education and geographic distribution, with a view to enhancing equity, effectiveness, and cost-efficiency as a vehicle for UHC;	2021–2025
e. Assess the need to raise the compulsory retirement age for health workers to 65 years;	2021–2025
f. Optimize deployment and progressive integration and institutionalization of the CHW programme into the civil service;	2021–2030
g. Improve capacity for HRH sustainability planning, management and regulation;	2021–2025
h. Establish distinct, but equally attractive, career paths in clinical service and health system management, and a system to support respective career development;	2021–2025
i. Institutionalize performance-based incentives, provide risk-based and career and professional growth offsetting incentives	2021–2023
j. Provide financial and non-financial incentives to recruit and retain health workers to serve remote and less-developed geographical areas and disadvantaged communities.	2021–2030

4.1.3 Strategic Pillar 3: Health Infrastructure

Strategic Objective 3: Realign the health service delivery environment to optimize functionality, efficiencies and performance for service delivery especially in deprived and challenged communities by 2035.

Strategic Commitments	When
We will:	
a. Establish, upgrade, maintain and sustain fully equipped health facilities and support structures to meet standard national blueprints and requirements.	2021-2025
b. Establish an organizational structure and develop management and maintenance information systems for the effective management of medical assets and health infrastructure development.	2021-2025
c. Advocate for the institutionalization of maternal biomedical training at universities, colleges and vocational institutions.	2021-2030
d. Improve health care waste management to reduce the impact on the environment through public private partnership;	2021-2023
e. Equip laboratories to ensure provision of integrated laboratory services up to the highest standard of quality testing, and which meet the national laboratory tool (mini kit) as the EHSP;	2021-2024
f. Provide each health facility with access to safe, reliable and basic amenities and ensure that the facilities meet minimum standards on infrastructure and sanitation, as well as on infection, prevention and control;	2021-2025
g. Legislate and institutionalize the licensing and accreditation of health facilities as the benchmark for setting facility standards as infrastructure of government and private health facilities.	2021-2025

4.2 Equitable Access to Health Care Services

Overcoming existing health inequalities requires a sustained multi-pronged strategy, to address both demand- and supply-side barriers and build the capacity of the MOHS. The UHC concept emphasizes the importance of embedding equitable provision of health care for all as the backbone strategy of the health sector. The Government is committed to ensuring that health systems and services are tailored to the needs of citizens, taking into account their socio-cultural, economic, and demographic characteristics, and consequently to improving the overall health outcomes.

The Roadmap focuses on strengthening service and demand generation through innovative and appropriate health technology and approaches, particularly to underserved populations, including the urban and rural poor. The various capacities of local communities will be enhanced to better promote good health and increase inclusive participation and ownership in local health decision-making processes. Stronger partnerships with locally active groups are required to empower women, and promote supportive cultural practices and healthy lifestyles in the respective communities. In this vein, the MOHS will partner with non-state actors in the provision of health services, making the services accessible to the entire population, especially those residing in challenged or deprived areas or areas where non-state actors hold a comparative advantage over public actors.

4.2.1 Strategic Pillar 4: Service Delivery

Strategic Objective 4: *Expand service coverage and increase equitable access to improve uptake in quality health care services at all levels, while special focus on community participation and ownership in service delivery by 2030.*

Strategic Continuum We will:	When
a. Remodel service delivery and clearly define the benefit packages that align with UHC principles;	2021–2030
b. Redesign, develop and sustain community-based PHC delivery model that delivers improved equitable access and quality of services, efficiency, and effectiveness;	2021–2025
c. Devise service delivery models comprising CHWs as part of integrated PHC teams. Define roles and typology of CHWs as part of a broader public policy perspective that considers the health system and health workforce planning as a whole;	2021–2030
d. Redefine the CHWs service package as part of the overall review of the EHSP and strengthen CHW capacity on delivering integrated PHC services on the pathwards achieving UHC;	2021–2026
e. Develop a sustainable referral pathway system to work in line with remodel 3rd emergency units in hospitals to strengthen the weak emergency medical services;	2021–2030
f. Develop a strategy and costed implementation plan to guide FHCT;	2021–2030
g. Develop a strategy for rehospitals focusing on standard health oriented design, construction, rehabilitation and management;	2021–2025
h. Design and implement appropriate integrated service delivery models, effectively linking primary care with hospital and post-hospital care (home or community care, palliative service, long-term care);	2021–2029
i. Establish and maintain core service packages for different levels of facilities;	2021–2023
j. Design and define the hospital service package and access strategy for coverage expansion for marginalized, informal and other groups;	2023–2026
k. Strengthen the weak blood services at hospital level and develop or update the strategy and implementation plan;	2021–2030
l. Strengthen service packages for prevention and management of NCD based on emerging epidemiological patterns;	2021–2030
m. Establish and sustain a system that ensures continuum of care across the RMNCAH life cycle and across disciplines;	2021–2030
n. Strengthen collaboration with non-state actors to provide health services in areas where they hold a comparative advantage as well as in deprived or challenged communities.	2021–2030

4.2.2 Strategic Pillar 5: Community Participation and Ownership

Strategic Objective 5: *Build and strengthen community systems to effectively shape and influence health service design, provision and outcomes at all levels by 2030*	
Strategic Commitments **We will:**	**When**
a. Redesign, position and continuously strengthen sustainable community structures and platforms;	2021–2030
b. Establish a system for the creation of effective community feedback mechanisms at all levels;	2021–2030
c. Redesign, position and sustain community structures to effectively engage individuals and communities in health decision-making, including on health promotion and disease prevention, diagnostics and treatment options, and rehabilitation, through effective health education;	2021–2030
d. Adopt a deliberate strategy to monitor and strengthen coordination and collaboration with CSOs (particularly community-based organisations), media outlets, and NGOs on community health development;	2021–2025
e. Strengthen community management structures, linking community activities to health service delivery structures;	2021–2025
f. Establish and strengthen community and health service interaction to enhance need-based and demand-driven provision of health services;	2021–2025
g. Revitalise community structures (using the bottom-up approach) and strengthen social accountability and transparency through the community approach;	2021–2025
h. Develop and engage community organisations, employers and employees in all forms of prevention and protection against the main communicable diseases and NCD risk factors and injuries;	2021–2025
i. Develop and implement a mechanism for social mobilisation for health security and emergency.	2021–2025

4.2.3 Strategic Pillar 6: Essential Medicines and Health Technology

Strategic Objective 6: *Foster an effective, efficient and sustainable pharmaceutical management system that meets priority health needs by 2030*	
Strategic Commitments **We will:**	**When**
a. Develop and implement a costed Supply Chain Management Strategic Plan;	2021–2025
b. Strengthen the governance and management structure for drugs and medical supplies;	2021–2030
c. Operationalise the National Safe Blood Services nationwide;	2021–2030
d. Strengthen the regulatory mechanisms and implementation of internationally accepted regulatory standards on efficacy, safety, quality and use of medicines and health technologies;	2021–2030
e. Strengthen quality assurance in (private and public) procurement and distribution mechanisms for essential medicines and health technologies, including traditional medicines;	2021–2027
f. Strengthen post-market surveillance mechanisms to detect, report and recall medicines and health technologies determined to be spurious/falsely-labelled/expired/falsified/counterfeit;	2021–2026

g.	Promote and support local manufacturing of essential medicines and commodities;	2021-2029
h.	Ensure rational use of medicines and deploy health technologies through interventions composed of a mix of educational, managerial and regulatory approaches;	2021-2028
i.	Reduce inefficiencies and wastage during procurement, storage, and delivery through transparent and accountable mechanisms;	2021-2030
j.	Put in place a system to adopt, update, disseminate and institutionalize necessary public health standards, health service delivery protocols, and clinical practice guidelines and/or pathways.	2021-2025

4.2.4 Strategic Pillar 7: Health Information, Technology and M&E

Strategic Objective 7: *Establish robust, digitally savvy, comprehensive, fully integrated, harmonized and well coordinated HMIS and M&E systems that effectively guide sector monitoring and impact evaluation, accountability, learning and evidence-based policy decision-making for NHS.*

Strategic Commitments	When
We will:	
a. Strengthen the HMIS governance framework and mechanisms;	2021-2023
b. Build sector capacity for District Health Information System management including data collection and management;	2021-2025
c. Institutionalize data utilization and digitalization of HMIS data collection, analysis and use;	2021-2028
d. Strengthen institutionalization and integration of HMISs in use currently – HMIS, the Community Health Information System, the Logistics Management Information System and the Integrated Human Resources Information System as well as other parallel health information systems;	2021-2029
e. Build strong information system infrastructure and take advantage of continuing Information Communication Technology (ICT) development;	2021-2030
f. Develop a long-term strategy for ICT infrastructure improvement, maintenance and sustainability;	2021-2030
g. Strengthen cybersecurity compliance of online applications, patient records, databases and individual treatment claims, where applicable;	2021-2022
h. Develop, implement and sustain a system for continuous data quality audit;	2021-2025
i. Strengthen the harmonization and integration of data collection, reporting and health information infrastructure within and between levels;	2021-2025
j. Monitor and evaluate policies, strategies, projects and programmes in a timely, effective and professional manner;	2021-2029
k. Ensure data interoperability.	2021-2030

4.3 Quality of Health Care Services

The Government is committed to ensuring that all health care services meet basic standards of quality and safety, and that these services are tailored to the needs and priorities of patients. Improving quality of health care services requires focusing on performance, across the entire health system. Ensuring quality of care in health facilities remains a persistent challenge due to poorly equipped health facilities with little or no basic amenities, a weak regulatory regime, erratic supply of drugs and medical supplies, absence of quality improvement mechanisms, poor clinical audits, and lack of performance reviews, among others curtailing

factors.[11] Advancing the quality of systems and services is ingrained in the National Health Care and Patient Safety Policy. The strengthening of procurement, supply chain management, human resource management, M&E and information management, sector financing, and other care systems is ultimately driven by the call to improve quality of services. Nevertheless, it is essential to focus on improving the quality at point of delivery, where people receive health services, from immunizations at remote, hard-to-reach clinics to specialty care provided at tertiary hospitals.

This strengthening requires that services meet basic standards of quality and safety, coordinated across multiple layers of public and private providers, centred on clients' needs and expectations. For this purpose, the UHC Roadmap focuses on developing minimum standards of care applicable to both public and private sector providers.

4.3.1 Strategic Pillar 8: Quality of Care

Strategic Objective 8: *Support provision at all levels of health care services that are safe, efficient, timely, equitable, accessible, respectful, responsive and people centred, using evidence based interventions that result in the best possible outcomes, and which are provided by a competent and compassionate workforce in an enabling environment in accordance with national standards by 2030.*

Strategic Commitments	When
We will:	
a. Develop and implement relevant policies, strategies and guidelines on quality management;	2021–2030
b. Establish quality certification and health facility accreditation standards and systems;	2021–2030
c. Strengthen the policy and regulatory environment and enhance the capacity of research to promote evidence-based decision-making and increase data visibility and use;	2021–2030
d. Establish regulatory systems for Allied Health Professionals;	2021–2030
e. Review, update and rollout existing guidelines and protocols to improve poor quality of care practices on sepsis, infection prevention control, patient and health worker safety, and implement National Quality Improvement Plans to sustain these products;	2021–2030
f. Conduct continuous supportive supervision, coaching, mentoring and monitoring of quality of care activities on a quarterly basis, and disseminate the findings to relevant stakeholders for action;	2021–2030
g. Develop and maintain a publicly available registry of licensed health professionals;	2021–2030
h. Institute and maintain systems for continuous quality improvement, including the use of quality and safety indicators;	2021–2030
i. Put in place informed consent and feedback mechanisms at all levels of service delivery (as is applicable);	2021–2030
j. Establish a system for families and communities to provide feedback on the patient journey – for example, through patient experience surveys and other means;	2021–2030
k. Institute reporting, conciliation and mediation mechanisms for medical error and complaints and concerns, with the involvement of a Patient Safety Ombudsman.	2021–2030

[11] Ministry of Health and Sanitation, Service Availability and Readiness Assessment (SARA) Report, 2017

4.4 Sustainable Health Financing

Despite the Government's strong political commitment and continued investment, increasing its annual health budget to 11 percent of total budget,[12] alongside high levels of development assistance, the population health indicators for Sierra Leone, such as the maternal and child mortality and morbidity rates, remain among the lowest performing in the world.[13]

Household OOP spending is the largest source of current health expenditure nationally, accounting for 64.7 percent of expenditure in 2018.[14] The heavy reliance on OOP payments poses not only financial barriers for service utilization, but can cause financial impoverishment – as citizens are forced to spend a substantial share of their income on health care. In the absence of a comprehensive regulatory fee structure or service charter, citizens face unfair financial risk burden when seeking care. To address this situation, the Government is in the process of implementing the Social Health Insurance Scheme as part of its UHC reform agenda, so as to increase financial risk protection by promoting pre-payment and risk-pooling in the health sector. There is also a critical need to formulate a comprehensive health financing strategy to garner adequate resources in the sector, ensure efficient and effective utilization of available resources, and streamline different social health protection schemes.

[12] Ministry of Finance, *Government Budget 2020*.
[13] Statistics Sierra Leone, *Sierra Leone: 2013 Demographic and Health Survey Key Findings*, Freetown, 2014, <https://dhsprogram.com/pubs/pdf/SR215/SR215.pdf>, accessed 10 July 2017.
[14] Ministry of Health and Sanitation, *Sierra Leone National Health Accounts 2017-2018*.

4.4.1 Strategic Pillar 9: Health Care Financing

Strategic Objective 9: *Establish innovative and sustainable health financing mechanisms that support resilient quality health care, with a special focus on the most vulnerable and disadvantaged populations by the year 2030*

Strategic Commitments We will:	When
a. Develop and implement a context-specific Health Financing Strategy with strong government, sector and partner commitments;	2021 – 2025
b. Increase domestic funding to ensure financial sustainability and ability to withstand economic volatility;	2021 – 2025
c. Support the full implementation of the SLeSHI to increase access and affordable quality health care services;	2021 – 2025
d. Increase government budget allocation to the health sector to at least 15%, in line with the Abuja Declaration; and allocate 12% of health budget to PHC;	2021 – 2025
e. Mobilize more resources from fines and taxation on practices that affect health status: tobacco, alcohol, carbon emission, deforestation, sanitation, corruption, mining practices affecting environment and water quality, health-related legal fines, property rates, market dues, vehicles and motorbike licences and fuel, etc.;	2021 – 2025
f. Design better targeting methods to ensure government subsidies/services reach disadvantaged populations;	2021 – 2025
g. Set appropriate patient cost-sharing arrangements to avoid bypassing of primary care, without compromising access to public and private sector services needed by the poor;	2021–2025
h. Introduce subsidies for both direct and indirect costs for individual-level services to improve health service uptake among those who cannot afford to pay, in particular for primary care in public and private facilities;	2021 – 2026
i. Build potential synergies by linking financial protection mechanisms in health with broader social protection mechanisms;	2021 – 2026
j. Provide targeted financial incentives, including vouchers or conditional cash transfers, matched with adequate supply, to improve use of services, especially preventive and routine services;	2021–2025
k. Ensure coherence in financing (funding flow) and service delivery, and promote coordination between different disease and specific health programmes, as well as donor initiatives.	2021–2030

4.5 Health Security and Emergency

Sierra Leone is prone to disasters and has been ranked 92 out of 195 countries in the latest Global Health Security Index,[15] a higher overall ranking than most comparable countries in the West African subregion. In recent years, the country has witnessed four successive shocks – the Ebola Virus disease epidemic, 2014-2015, the iron ore mining collapse, 2015-2016, the flooding and mudslide that occurred in Freetown in 2017, and the ongoing global Coronavirus disease 2019 (COVID-19) pandemic, each of which has tested the responsiveness and resilience of the health system, and largely decimated the health care sector. The evidently poor preparedness and response to these outbreaks in Sierra Leone could be attributed to the weak

[15] Global Health Security Index, '2019 Global Health Security Index', < https://ghsindex.org/>.

health systems currently in place. The weak health system causes disparities in coverage and access to health delivery services and information, which results in increasing exposure of the population to public health threats, and thus poor health outcomes.

A weak surveillance system coupled with weak cross-border disease surveillance and security constitutes one of the bottlenecks most deserving of system strengthening. An approach to strengthening global health security and emergency will require the development of mechanisms for inter-sectoral collaboration using the One Health approach. In 2016, Sierra Leone voluntarily conducted the Joint External Evaluation on the 19 core technical capacities for surveillance and response, which informed the development of the National Action Plan for Health Security 2018-2022 to implement the International Health Regulations 2005. The MOHS should in collaboration with other MDAs, HDPs, the private sector and communities mobilize the necessary resources to implement the costed National Action Plan for Health Security. It would also be appropriate to consider mobilizing resources, including domestic financing, advocating for establishing and institutionalizing a Public Health Agency, and ensuring utilization of quality improvement approaches to achieve greater results.

4.5.1 Strategic Pillar 10: Health Security and Emergency

Strategic Objective 10: Establish and maintain [illegible] appropriate disease surveillance mechanisms, robust epidemic outbreak warning system capable of preventing, detecting and adequately responding to public health threats and hazards by 2030.

Strategic Commitments We will:	When
a. Strengthen the legislative framework to ensure adequate administrative and statutory provisions in compliance with the International Health Regulations and the Global Health Security Agenda to achieve UHC;	2021–2030
b. Strengthen effective surveillance and response mechanisms for timely detection and risk factor detection, prevention, control and evaluation;	2021–2030
c. Establish surveillance and response mechanisms for multisectoral and multilateral cross-border collaboration to ensure rapid response to food safety emergencies and outbreaks of food-borne diseases;	2021–2030
d. Operationalize zoonotic diseases surveillance mechanisms;	2021–2030
e. Establish effective permanent public health security and response capacity and manage specific health risks across sectors, such as emerging and re-emerging diseases, food contamination and radioactive substances, in all public settings;	2021–2030
f. Delineate core basic health services at each level and document the location of critical health resources for emergency responses – human resources, medicines, information and logistical supplies;	2021–2030
g. Build community awareness, readiness and skills for disaster prevention, preparedness, response and recovery;	2021–2030
h. Increase the efficiency, effectiveness and impact of emergency response to disasters at the community level;	2021–2030
i. Foster effective cross-sectoral partnerships and collaborations with local governments to support a robust culture of health resilience where individuals and community groups actively participate in community disaster prevention, preparedness, response and recovery;	2021–2030
j. Revitalize sanitary inspection of food, compounds, markets and other public places;	2021–2025
k. Establish an infectious disease facility to provide adequate case management for disease outbreaks of border crossings;	2021–2026
l. Strengthen cross-border partnerships with joint committees for an effective and operational approach to disease surveillance, prevention, detection, and response.	2021–2028

5 IMPLEMENTATION OF THE UHC ROADMAP

The overall responsibility of implementing the UHC Roadmap rests primarily with the MOHS, under the direct supervision of the Chief Medical Officer, as the National Coordinator. The rollout of the Roadmap will be coordinated by the National Steering Committee with oversight by the Office of the President. The MOHS will also collaborate with MDAs, HDPs, the private sector, both national and international NGOs, academia and CSOs to implement the Roadmap.

The main vehicle for implementation of the Roadmap is the NHSSP for UHC (Figure 4). The NHSSP and its subsequent Annual Work Plans and Budget will translate this Roadmap into action.

Figure 4: Goals in Delivering UHC

Source: Technical Assistance from WHO Sierra Leone Country Office

5.1 Measuring Performance

The sector performance on implementation of the UHC Roadmap will be measured using the following three instruments:

1. M&E Plan and RF of the NHSSP for UHC;
2. Mid-Term Reviews; and
3. Regular Performance Reviews (biannual, annual, etc.).

5.2 M&E Plan and Results Framework

The M&E Plan and RF of the NHSSP for UHC will monitor sector performance on implementation of the UHC Roadmap, on an annual basis. The Framework sets out a range of key indicators at goal, outcome, output and input levels of the NHSSP logic model. A compendium of core indicators provides detailed information for each indicator on issues such as levels of disaggregation, periodicity, means of verification, assumptions, reliability, etc. The RF will also utilize information and data from routine health management information systems and periodic national surveys.

9.3 Mid-Term Reviews

The MOHS will commission a Mid-Term Review of the NHSSP for UHC. The review will be carried out by a team of external experts (Statistics Sierra Leone) with the aim of assessing the progress toward achieving the outcomes and results of the NHSSP. It will also review the sector management approach, including health aid/grant effectiveness. The recommendations emanating from the Mid-Term Review will guide the MOHS and its development/implementing partners to make necessary programmatic and system-related interventions in order to achieve the NHSSP results over the remaining implementation periods.

9.4 Regular Performance Reviews

Quarterly/biannually and annual reviews will assess the progress of various health interventions guided by the NHSSP for UHC. The major thrust of the assessment will be to find out whether the inputs are sufficient, and whether the outputs are performing sufficiently to achieve the desired outcomes and impacts. These reviews will be streamlined with the UHC Roadmap priority direction pillars.

REFERENCES

Development Tracker, 'Saving Lives in Sierra Leone 2016', updated 6 November 2020, <https://devtracker.dfid.gov.uk/projects/GB-GOV-1-300016>.

European Patients Forum, *Taking Action – A Roadmap to Achieving Universal Health Coverage for All by 2030*, Brussels, 2017, <https://www.eu-patient.eu/globalassets/campaign-on-access/taking-action---a-roadmap-to-achieving-universal-health-coverage-for-all-by-2030.pdf>.

Global Conference on Primary Health Care, *Declaration of Astana*, Astana, Kazakhstan, 25 and 26 October 2018, <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>.

Government of Guyana, *Strategy for Universal Health Coverage*, Georgetown, 2014.

Government of Sierra Leone, *Sierra Leone's Medium-Term National Development Plan 2019–2023*, Freetown, 2019, <<https://www.imf.org/en/Publications/CR/Issues/2019/07/09/Sierra-Leone-Economic-Development-Documents-National-Development-Plan-2019-23-47099>.

Government of Sierra Leone, *Community Disaster Risk Management and Drainage System in Freetown*, Freetown, 2018.

Jalloh, Alpha, *Sierra Leone - AFRICA P163864 Health Service Delivery and System Support Project - Procurement Plan (English)*, Washington, D.C., World Bank Group, 2020, <http://documents.worldbank.org/curated/en/230321598150836865/Sierra-Leone-AFRICA-P163864-Health-Service-Delivery-and-System-Support-Project-Procurement-Plan>.

Kargbo, Moses A., 'Sierra Leone: World Bank Approves $50 Million Grant to Improve Education Quality', Press Release No: 2020/156/AFR, The World Bank, Washington, D.C., 2020.

Kirton, John, and Ilona Kickbusch, eds., *Health: A political choice. Delivering Universal Health Coverage 2030*, Global Governance Project, London, 2019, <https://www.healthpolicy-watch.org/wp-content/uploads/2019/06/f736fefa-3c34-47e2-b6f7-0218bffe0075.pdf>.

Ministry of Finance of Sierra Leone, *Government Budget and Statement of Economic and Financial Policies: For the Financial Year, 2020*, Freetown, 2019, <https://mof.gov.sl/wp-content/uploads/2019/11/FY-2020-Budget-Speech-and-Profile-1.pdf>, accessed 15 September 2020.

Ministry of Health and Sanitation of Sierra Leone, *National Health Accounts Study 2017 & 2018*, Freetown, 2019.

Ministry of Health and Sanitation of Sierra Leone, *Sierra Leone National Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy 2017–2021*, Freetown, 2017, <https://www.afro.who.int/sites/default/files/2017-11/Sierra%20Leone%20National%20Reproductive%2C%20Maternal%2C%20Newborn%2C%20Child%20and%20Adolescent%20Health%20Strategy%202017-2021.pdf>.

Ministry of Health and Sanitation of Sierra Leone, *Human Resources for Health Policy 2017–2021*, Freetown, 2017, <https://www.afro.who.int/sites/default/files/2017-05/hrhstrategy2017.pdf>.

Ministry of Health and Sanitation of Sierra Leone, *National Community Health Worker Policy 2016–2020*, Freetown, 2016, <https://www.resilientinstitutionsafrica.org/sites/default/files/2018-08/%5BSierra%20Leone%5D%20National%20CHW%20Policy%202016-2020.pdf>.

Ministry of Health and Sanitation of Sierra Leone, *Sierra Leone Basic Package of Essential Health Services 2015-2020*, Freetown, 2015, <https://mohs2017.files.wordpress.com/2017/06/gosl_2015_basic-package-of-essential-health-services-2015-2020.pdf>.

Ministry of Health of Ghana, *Roadmap for Attaining Universal Health Coverage 2020–2030*, Accra, 2020.

The Global Fund, *Audit Report: Global Fund Grants to the Republic of Sierra Leone*, Office of the Inspector General, Geneva, 2019, <https://www.theglobalfund.org/media/8204/oig_gf-oig-19-001_report_en.pdf>.

UHC 2030 International Health Partnership, *Universal Health Coverage Advocacy Guide: A guide to promote health systems strengthening to achieve universal health coverage*, Geneva, 2018, <https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/Advocacy/UHC_Advocacy_Guide_March_2018_final.pdf>.

World Health Organization Regional Office for Africa, *Health Systems and Services for UHC and Other Health-Related SDG Targets: Sierra Leone Scoping Mission Report, June 10th–14th 2019*, Brazzaville, 2019.

World Health Organization, *Roadmap for Access to Medicines, Vaccines and Other Health Products, 2019-2023: Comprehensive support for access to medicines and vaccines*, Geneva, 2019, <https://apps.who.int/iris/bitstream/handle/10665/330145/9789241517034-eng.pdf?sequence=1&isAllowed=y>.

World Health Organization, *Universal Health Coverage: Moving Towards Better Health. Action Framework for the Western Pacific Region*, Geneva, 2016, <https://iris.wpro.who.int/bitstream/handle/10665.1/13371/9789290617563_eng.pdf>.

World Health Organization, *The Global Push for Universal Health Coverage*, Geneva, 2014, <https://www.who.int/health_financing/GlobalPushforUHC_final_11Jul14-1.pdf>.

World Health Organization Regional Office for Africa, *Framework for the Implementation of the Ouagadougou Declaration on PHC and Health Systems in Africa*, Brazzaville, 2010, <https://www.afro.who.int/sites/default/files/2017-06/framework-for-implementation-ouaga-9-4-10.pdf>.

World Health Organization Regional Office for Africa, *Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health in Africa in the New Millennium. A declaration by the Members States of the WHO African Region*, Brazzaville, 2008, <https://www.afro.who.int/sites/default/files/2017-06/decouagadougou_declaration_eng.pdf>.

ANNEXES

ANNEX 1: Recommendations and Next Steps

A. Consider developing the Prioritized Operational Plans for UHC implementation.

B. Advocate for the development of health in all other policies in collaboration with other MDAs.

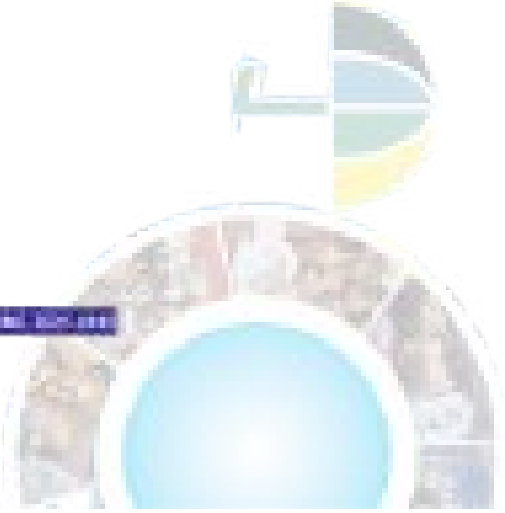
C. Institute all health funds in our budget.

D. Pilot UHC followed by upscaling.

E. Focus on improving the PHC system to implement UHC in Sierra Leone.

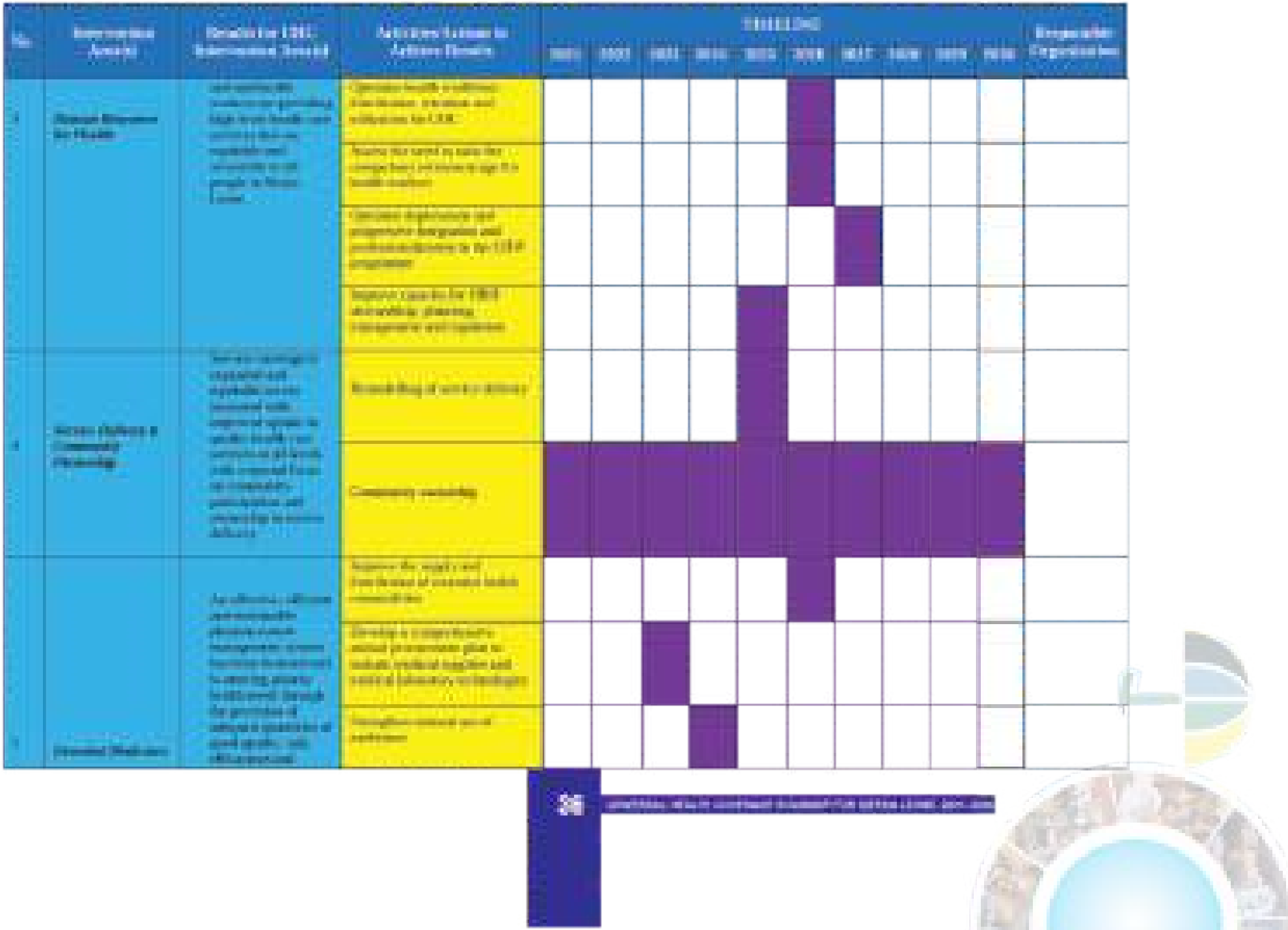
F. Build the capacity of DHMTs, placing this activity at the forefront in managing the UHC implementation process.

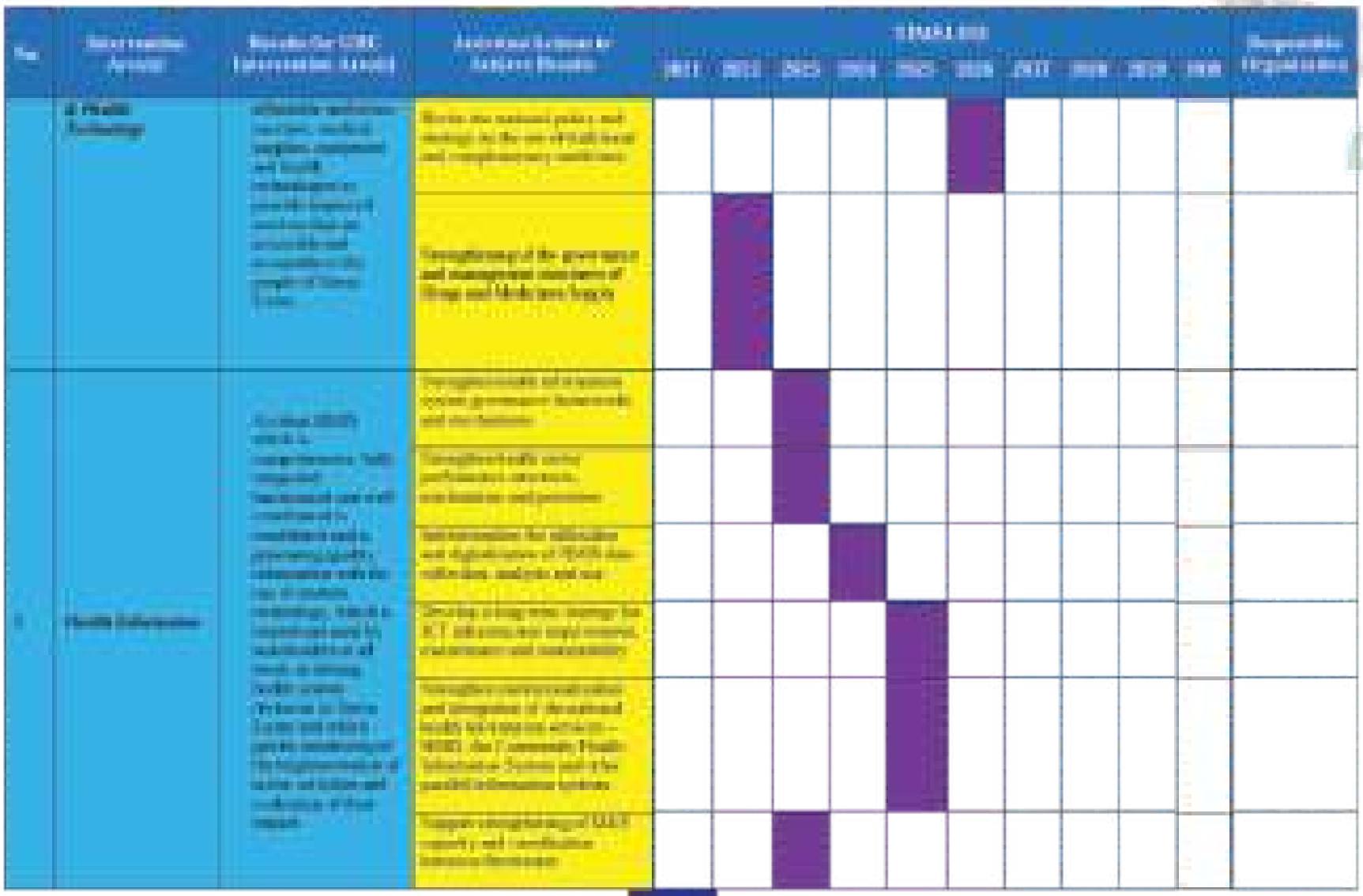
G. Provide effective supervision to ensure optimal functioning of all structures and allow the achievement of UHC.

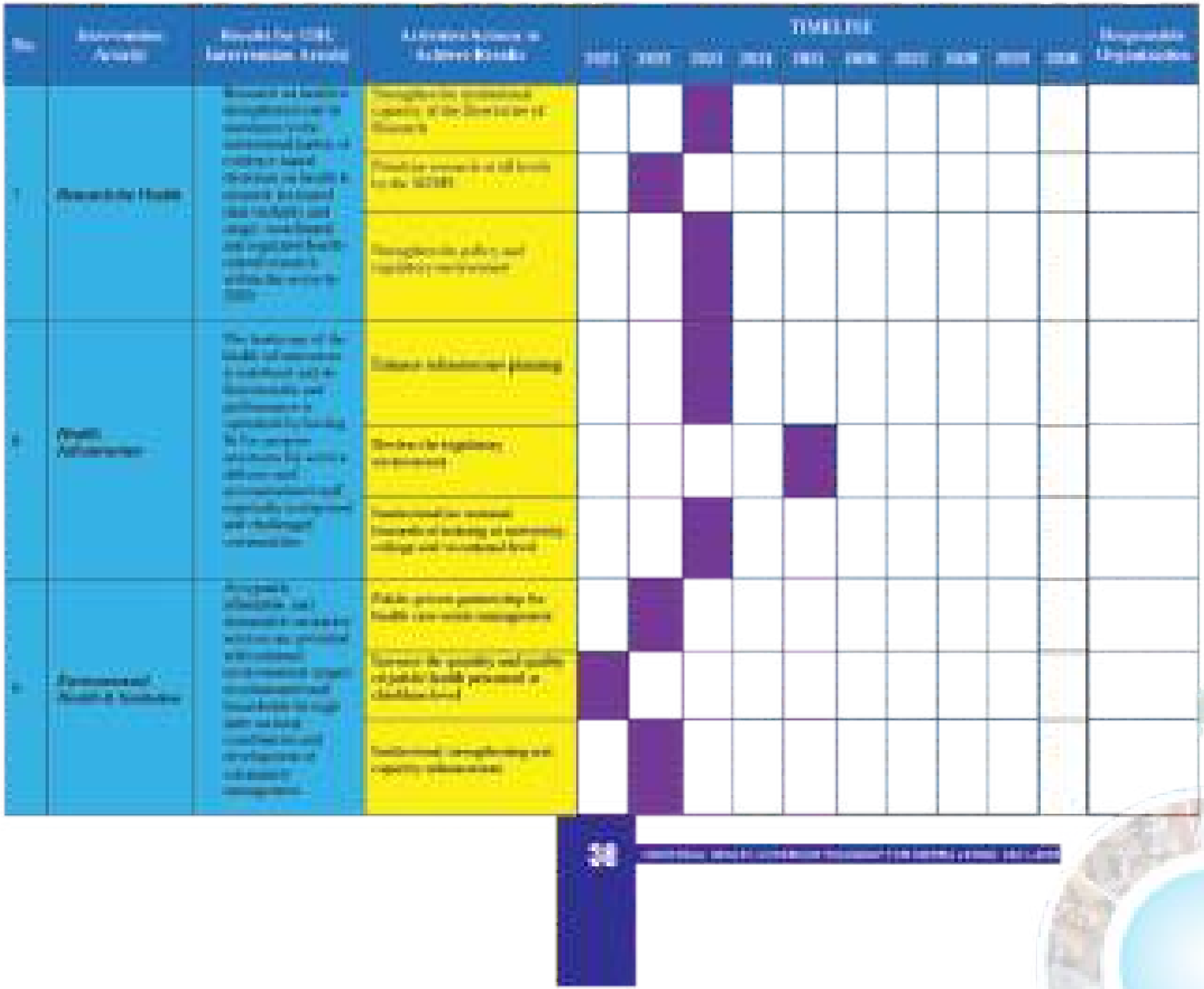


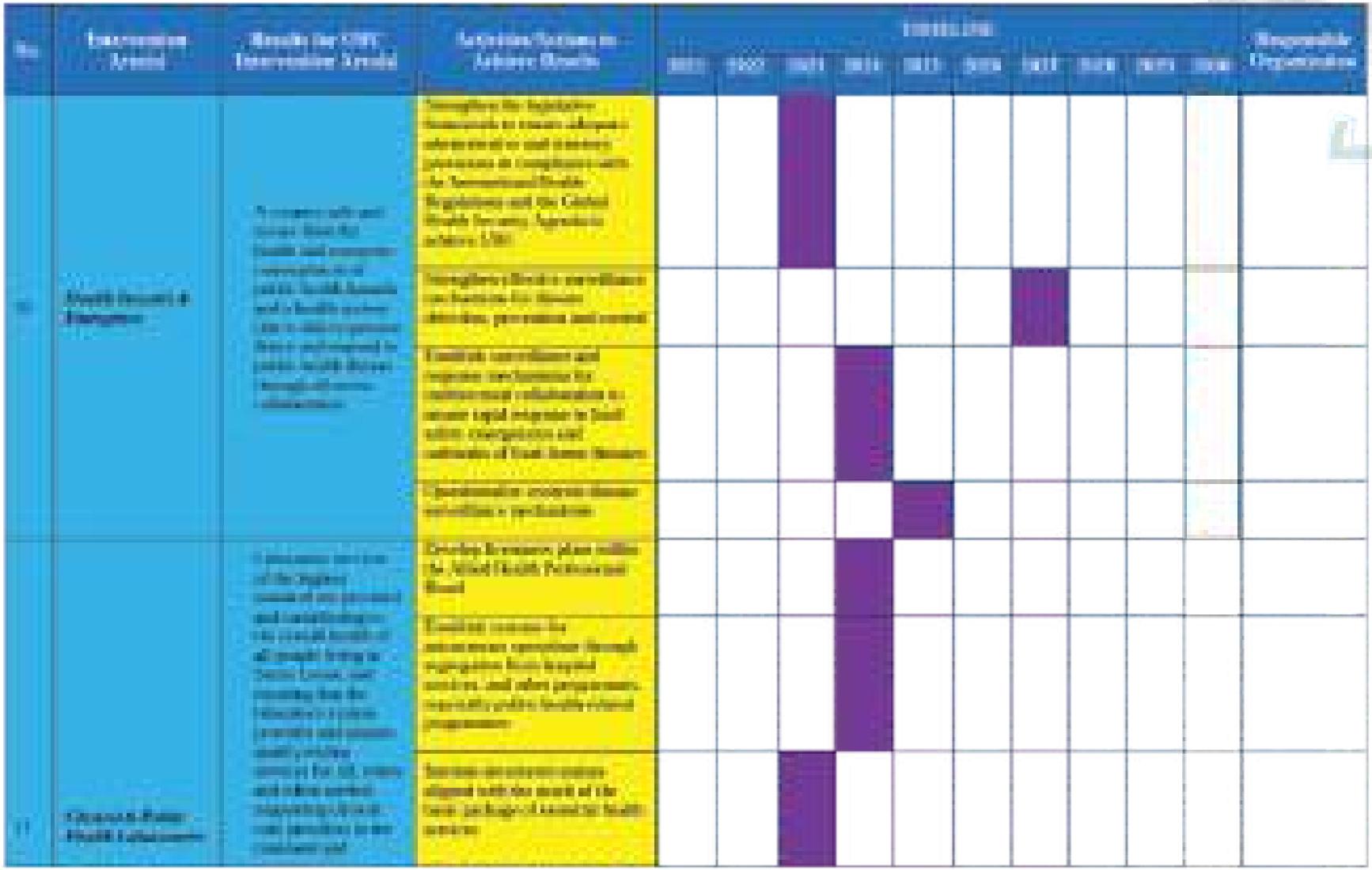
ANNEX 2: Framework for Implementation of the UHC Roadmap

No.	Intervention Area(s)	Results for UHC Intervention Area(s)	Activities/Actions to Achieve Results	TIMELINE										Responsible Organizations
				2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	
1	Leadership & Governance													
2	Health Financing													









No.	Intervention Area	Results for UHC Intervention Areas	Activities/Actions to Achieve Results	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Responsible Organization
		[illegible]	Procurement of a full complement of consumables, reagents and supplies to meet the national laboratory test menu based on the [illegible]	X										
[illegible]	Blood & Blood Products (National Safe Blood Services)	[illegible]	Operationalize a national headquarters for blood services outside of the hospital setting				X							
			Routine supply of [illegible] blood and blood products and [illegible]	X										
			Availability of adequate staff to run the National Safe Blood Services programme	X										
			Sensitize communities and the general public to increase the impact of mobile blood drives			X								
			Ensure availability of reagents, screening kits and consumables	X										
[illegible]	Quality of Care	Health care is safe, effective, timely, … and people-centred … evidence-based … [illegible]	Eliminate harm including preventable injuries and medical errors to the patient						X					
			Effectiveness: Health care is based on scientific knowledge and evidence-based guidelines						X					
			People-centredness: providing care that is respectful of and responsive to individual patient preferences, needs and values						X					

No.	Intervention Area(s)	Results the UHC Intervention Area(s)	Activities/Actions to Achieve Results	TIMELINE 2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Responsible Organisation
		acceptability, integrated and comprehensive workforce in an enabling environment to ensure safe and [illegible]	Timeliness: Keep delays in providing and receiving services to a minimum.											
			Efficiency: Avoid waste, including waste of equipment, supplies, ideas and energy.											
			Equity: providing care that does not vary in quality on account of personal characteristics such as gender, ethnicity, geographic location, or socio-economic status.											
			Integration: The care received across facilities and providers is coordinated.											
13	M&E and Accountability Framework	To ensure comprehensive, fully integrated, harmonised and well-coordinated M&E system to establish and assess the monitoring of the implementation of the sector activities and outcomes and outputs	Strengthen health information systems governance, frameworks and mechanisms											
			Strengthen the health sector performance, structure and build sector capacity for District Health Information System management, data collection and management											
			Strengthen basic infrastructure and integration of parallel information systems, strengthen the M&E capacity, and develop a long term strategy for ICT infrastructure, improvement, maintenance and sustainability											
			Implement patient-level data collection and improve collection of data on deaths and causes of death, as well as usage of data for decision making											

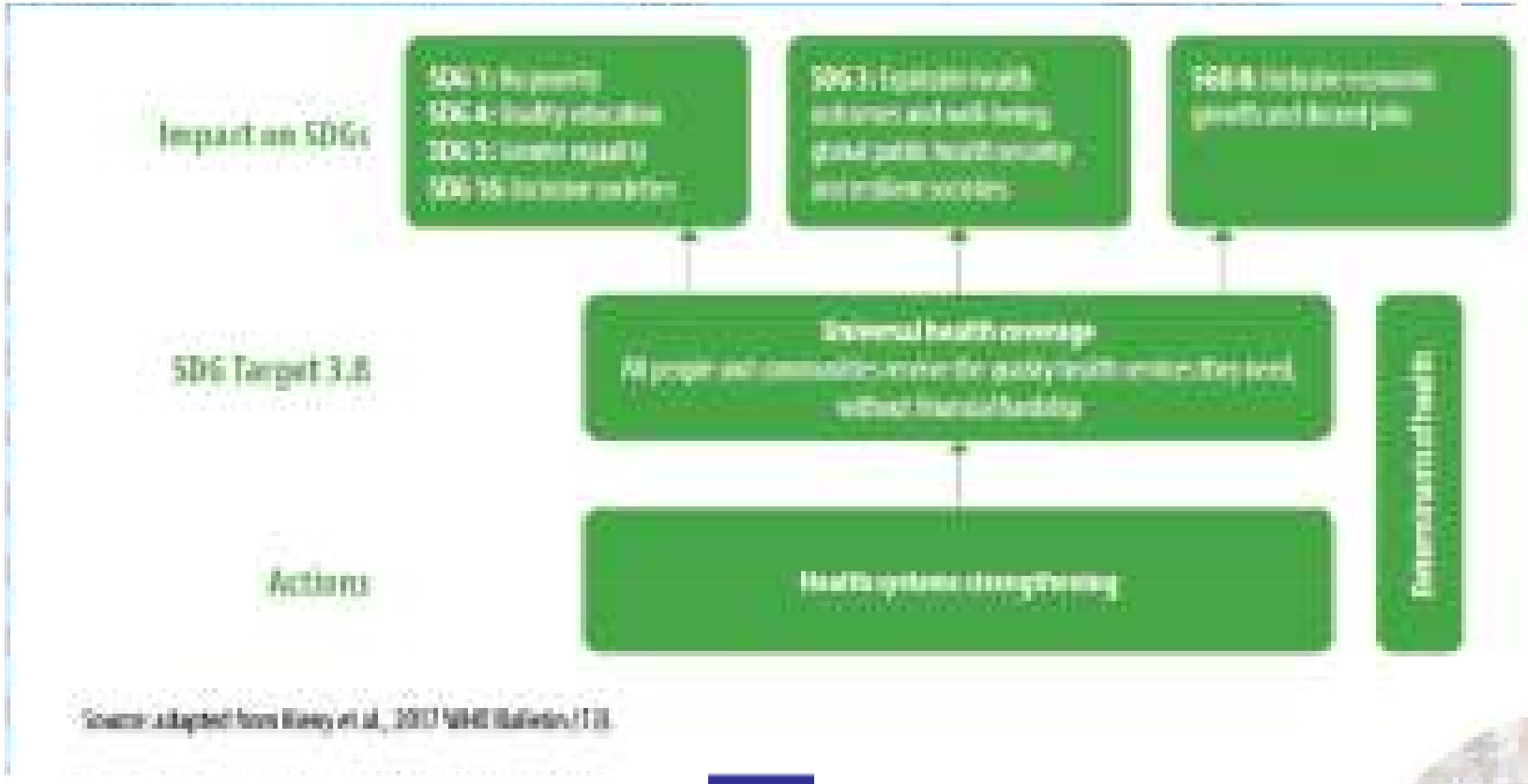
ANNEX 3: List of Contributors

Name	Place of work	Position
Hon. Prof. Alpha T. Wurrie	Ministry of Health & Sanitation (MOHS)	Minister of Health
[illegible]	MOHS	[illegible]
Hon. Dr. Amara Jambai	MOHS	Deputy Minister of Health II
[illegible]	MOHS	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
Prof. Dr. Mohamed Samai	Directorate of Training & Research	Director
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
Matron Mary Fullah	[illegible] of Nursing and Midwifery	Chief Nursing and Midwifery Officer
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

Name	Place of work	Position
Dr. Samuel Smith	Directorate of Disease Prevention & Control	Director
Mr. Emile Koroma	Directorate of Human Resources for Health	Director
Dr. Janet Kayita	[illegible]	Coordinator, Basic Package of Essential Health Services, [illegible] Cluster
Ms. Yuki Suehiro	UNICEF	Chief Health and Nutrition
Dr. Hailemariam Legesse	UNICEF	Health Specialist, Community Health
Dr. [illegible]	UNICEF	Health Specialist, Maternal and Newborn Health
Mr [illegible] Wright	UNICEF	Health Specialist, Policy and Planning
[illegible]	World Bank	Country Manager
[illegible]	World Bank	Senior Specialist Health and Nutrition
Mr. Mohamed [illegible]	GFF	Financing Specialist
Dr. [illegible]	GFF	Policy Specialist
Dr. Tom Sesay	EPI Child Health	Programme Manager
Dr. Francis Moses	[illegible] Programme	Programme Manager
Matron Margaret [illegible]	Quality of Care Programme	Programme Manager
Dr. [illegible] Koroma	Clinical Laboratory	Programme Manager
Ms. Doris Harding	Public Health Laboratory	Programme Manager
Dr. [illegible]	Office of the CMO, MOHS	Technical Advisor
Dr. [illegible]	WHO/MOHS	Consultant
Dr. [illegible]	DHMT, Bo	District Medical Officer
Dr. [illegible]	DHMT, Kenema	District Medical Officer
Dr. [illegible]	DHMT, [illegible]	District Medical Officer
Dr. [illegible]	DHMT, Bombali	District Medical Officer
Dr. [illegible] Kamara	DHMT, WAU	District Medical Officer
Lt. Col. Dr. [illegible]	34 Military Hospital, RSLAF	Commanding Officer, Joint Medical Unit
Dr. [illegible]	MOHS	Physician Specialist

Name	Place of work	Position
[illegible]	[illegible]	[illegible]
Dr. Sylvia Kwasie	DHMT, WAR	District Medical Officer
Mr. Paul Sengeh	FOCUS 1000	Director Research and Evaluation
Mr. Momoh Jimmy	PIH	Director Health Policy and Community Engagement
Ms. Penny Walker-Robertson	Foreign Commonwealth Development Office	Health Policy Desk Officer
Dr. D'Ameilda Selassi	World Health Organization	Cluster Lead - Health Systems Strengthening

ANNEX 8: Flow of Work – Investing in Health Systems



NOTE


HEALTH IS A
HUMAN RIGHT

Nurturing a Healthy Population:
Our Roadmap to Human Capital Development