

## **Assessment of readiness for a Sector Wide Approach for Health in Sierra Leone**

### **KIT Development Policy & Practice**

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## **Acknowledgements**

This study is part of a series of country studies undertaken by KIT health team concerning assessment of readiness for a sector wide approach for health in countries emerging from prolonged conflict. This particular study focuses on the Sierra Leone health sector with attention to the current status of policy, management and coordination arrangements and it's evolution since the end of the humanitarian crises in 2002. We wish to express our appreciation to Dr Magnus Gborie, Director of Planning and Information (MoHS) and Yayah Conteh, Donor/NGO liaison official (MoHS) who collaborated on the content and in-country organization of this study. A special word of appreciation to the development partners who actively participated in the interviews and debrief workshop, to Dr Clifford Kamara who has provided a strong 'institutional memory' on health developments in Sierra Leone and to all the Ministry of Health and Finance staff who were so willing to dedicate their time to dialogue and interviews. A special word of appreciation to our peer reviewers; Petra Vergeer and Jacob Hughes who have both devoted time to review of the methodology design and the report. Thanks to the KIT administration and secretariat staff who supported the logistics and back up for the field study from Amsterdam.

## Acronyms and Abbreviations

ADB	African Development Bank
DACO	Development Assistance Coordination Office
DAD	Development Assistance Database
DFID	UK Department for International Development
DGIS	Dutch Ministry of Foreign Affairs
DHMT	District Health Management Team
DMO	District Medical Officer
DP	Development Partner
EC	European Commission
EPI	Expanded Program on Immunisation
FP	Family Planning
GBS	General Budget Support
GDP	Gross Domestic Product
GoSL	Government of Sierra Leone
GNI	Gross National Income
HIPC	Heavily Indebted Poor Countries
HRM	Human Resource Management
IRCBP	Institutional Reform and Capacity Building Project
IFMIS	Integrated Financial Management Information System
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
KIT	Royal Tropical Institute
LGFD	Local Government Finance Department
MCH	Mother and Child Health
MDBS	Management Database System
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MLI	Ministerial Leadership Initiative
MMR	Maternal Mortality Rate
MoHS	Ministry of Health & Sanitation
MOFED	Ministry of Finance and Economic Development
MTEF	Medium Term Expenditure Framework
MTRP	Medium Term Rolling Plan
NASSIT	National Agency for Social Security
NGO	Non Governmental Organisation
NHSSP	National Health Sector Strategic Plan
OECD	Organisation for Economic Cooperation
PETS	Public Expenditure Tracking Survey
PEVA	Public Expenditure Financial Accountability
PHC	Primary Health Care
PHU	Primary Health Unit
PIU	Program Implementation Unit
PPP	Public Private Partnership
PRGF	Poverty Reduction Growth Facility
PRSP	Poverty Reduction Strategy Paper
RCH	Reproductive and Child Health
SSA	Sub Sahara Africa
SWAp	Sector-Wide Approach
SWOT	Strengths –Weaknesses - Opportunities - Threats
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WB	World Bank
WHO	World Health Organisation

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## 1 Introduction

In the framework of support to health systems development in fragile states, the Royal Tropical Institute (KIT) has undertaken formative research on the subject of aid effectiveness, with two studies published in 2008<sup>4</sup>. This current study is part of a series of papers on the issue of post conflict health sectors and their readiness for moving to a sector wide approach.

The literature offers many definitions of sector wide approaches, while acknowledging that it is a set of principles, an approach and not a blueprint (Cassels, 1997). One of the most commonly quoted and comprehensive definitions is that of Brown et al (2001)

*All significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector and progressing towards relying on Government procedures for all funds<sup>5</sup>.*

In fact, SWAp is a way of working together between government, development partners and other key sector stakeholders (European Commission<sup>6</sup>). It is a process that aims at broadening government and national ownership over public sector policy and resource allocation decisions within the sector, increasing the coherence between policy, spending and results, and reducing transaction costs. SWAp can be supported by one or more sector programmes, which in turn can be financed by using different aid modalities (e.g. sector budget support, pooled funds, project aid).

One of the priority areas for moving forward with health sector reform in post conflict contexts is to generate a better understanding of the progress that has been made with improving coherence between the government and development partners. Lessons can also be learned from more stable contexts on the application of a sector wide approach for health to more fragile contexts. Experiences with SWAps in more stable environments have shown that they can contribute to improving national ownership and leadership, enhanced coherence between policies, spending and results. It can also subscribe to donor harmonisation and alignment thus promoting reduced transaction costs and greater transparency & accountability<sup>7</sup>. SWAp thereby have demonstrated potential to anchor the varying elements of ownership, partnership, coordination, shared mechanisms and monitoring processes.

A number of post conflict countries, too, have started to experiment with early stages of SWAps. The evidence to date demonstrates that when shifting from the humanitarian to the development mode, more streamlined and coordinated policy and management processes can assist in strengthening of health systems and service delivery in early recovery settings. The fragility of a country will have major implications for how the government and development partners interact and move forward to reach a situation of alignment and optimal partnership. Particular attention therefore needs to be paid to the determinants that will influence the trust and understanding which is implicit within a SWAp. Determinants will include; government capacity and legitimacy of government, donor policy and behaviour and choice of aid mechanisms that has implications for the degree of state partnership that is feasible.

<sup>4</sup> Canavan, A., Vergeer, P. & Bornemisza, O., 2008, Post-conflict Health Sectors: The Myth and Reality of Transitional Funding Gaps, Royal Tropical Institute, Netherlands, in collaboration with the Health and Fragile States Network and funded by DFID.

Vergeer, P. Canavan, A., & Rothmann, I., 2009. A rethink on the use of aid mechanisms in health sector early recovery. Royal Tropical Institute, Netherlands funded by the Dutch Ministry of Foreign Affairs (DGIS).

<sup>5</sup> Brown et al (2001), Experience with implementing sector wide approaches, ODI.

<sup>6</sup> EC (2007), Guidelines Support to Sector Programmes.

<sup>7</sup> Literature review on Sector Wide Approach for health (2009), Royal Tropical Institute of the Netherlands.

Following the peace agreement of 2002, Sierra Leone is in the recovery process which includes rethinking governance, policy and management arrangements as well as engagement with civil society. The recent national health strategy draft advocates for a move towards a sector wide approach. This calls for a thorough assessment of overall readiness of the Ministry of Health and development partners to deliver such an approach. The study was undertaken in order to deliberate on all six elements of a SWAp, which are commonly regarded as the key building blocks for the health sector.

## 2 Methodology

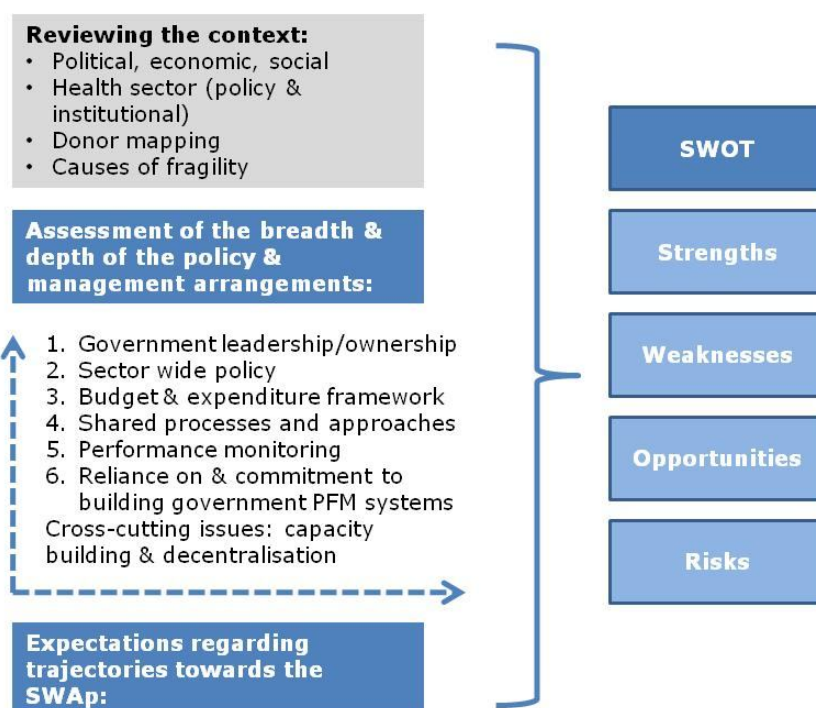
This study involved an extensive literature review documenting past and present experiences in use of sector wide approaches globally. In July 2009, a field study was conducted by a team consisting of two health systems specialists with extensive experience of working in post conflict contexts and a specialist in public financial management and aid effectiveness. The field work consisted of analysis of primary and secondary data (HMIS, IFMIS), interviews with government & development partners and visits to two districts. (See Annex 1 for Key Informants)

This review of the readiness of Sierra Leone's health sector for SWAp consists of an assessment of the breadth and depth of the six elements; these core elements of a sector wide approach are drawn from operational definitions as provided by OECD DAC:<sup>8</sup>

1. Government leadership of the sector in a sustained partnership;
2. A clear nationally-owned sector policy and strategy, derived from broad-based stakeholder consultation and which is supported by all significant funding agencies;
3. A (medium term) budget & expenditure framework which reflects the sector policy;
4. Shared processes and approaches for planning, implementing, managing the sector strategy;
5. A sector performance framework monitoring against jointly agreed targets;
6. Commitment to move to greater reliance on government financial management and accountability systems;

The analytical framework is presented in *Figure 1* below.

**Figure 1 Analytical Framework**



Each of the six elements of this framework listed below was analysed in terms of breadth and depth while contextual factors as indicated were reviewed in

<sup>8</sup> OECD/DAC (2006), Harmonizing Donor Practices for Effective Aid Delivery, Volume 2. Assessment of readiness for a Sector Wide Approach for Health in Sierra Leone

terms of likely impact on the progress of the health sector. The breadth of a SWAp refers to whether a sector has achieved all or some of the six elements in place, while the depth refers to the effectiveness with which these basic six elements are being implemented. The analysis will take a cross-cutting approach to decentralisation and capacity building; these issues have also been assessed extensively in recent studies, reference is therefore largely made to previous findings as relevant to their contribution to SWAp.

Together with a review of the expectations of the different actors towards strengthening current sector-wide efforts, the analysis will generate strengths and weaknesses of the current policy, management and coordination arrangements in the health sector as well as future opportunities and risks. The conclusions and recommendations are provided within a framework of short to medium term actions for the Ministry of Health & Sanitation and development partners. Although in concluding the state of readiness, the hierarchy of the six elements as presented above can help shape the next steps and sequencing of a SWAp, they are considered as essential and mutually enhancing for the purpose of achieving a SWAp.

## 3 The transition to development in Sierra Leone

### 3.1 Political, economic and social context

#### *Political context*

In February 2002, peace was declared in Sierra Leone after a ten year period of instability and brutal civil war. Since then, the collaboration between the government and the international community has stabilized the security situation and put an end to widespread violence and fear and it is now entering a more stable recovery state. Sierra Leone has a population of approximately 6,294,774 (July 2008 est.)<sup>9</sup>. Administratively the country is divided into the Western Area, 3 regions namely; Northern, Southern and Eastern and Western which are divided into 12 districts and 149 chiefdoms. The Western region is divided into Western Urban where the capital city Freetown and the seat of Government is located; the other part is the Western Rural. There are 19 Local Government Authorities, of which 13 districts and 6 cities.

Government of Sierra Leone (GOSL) finalised an Interim PRSP in July 2001, a first full PRSP (2005-2007) was finalised in mid 2005 and the second PRSP (2008-2012) has just been published. As summarised by the Joint EC/DFID Country Strategy<sup>10</sup>, progress towards rebuilding the main pillars of the state is noteworthy in terms of reconstruction, resettlement and reintegration. Democratic and effective governance however remain elusive and effective oversight mechanisms do not yet exist. An inefficient civil service due to years of mismanagement and neglect, lack of training and low wages, combined with overall weak government capacity and high corruption means that GOSL is unable to deliver effectively basic services to citizens in light of overall government willingness to reform. This is not much different for the health sector. A recent study undertaken by the Anti-Corruption Commission in Sierra Leone notes that "corruption in the Ministry of Health and Sanitation ranges from informal payments for services, healthcare fraud and conflict of interest to inexplicable financial transactions. These practices have endangered the viability of basic service delivery and have posed serious threats to the maintenance of an effective health delivery service system nationwide."<sup>11</sup>

#### *Economic context*

Since the end of conflict in 2002, Sierra Leone's economy has stabilised. The economic recovery from the very low base after the war is explained to a large extent by a return to normality - the rehabilitation of agricultural lands and increased private investment. The economically active population is estimated at 40 per cent of the population but about 2 million individuals in Sierra Leone were in the informal sector in 2004 (Labor Force survey) In recent years, macroeconomic performance was mixed. Output growth was strong and broad-based at a rate of 6.4% in 2007, but inflation reverted to 17 percent in September 2007 and remained high throughout 2008, largely due to the global food and fuel crisis. While Sierra Leone real GDP growth has exceeded the averages of SSA countries for the past five years, GDP per capita in constant dollars remains below average. With the lowest domestic revenue-to-GDP ratio in SSA, Sierra Leone has very little fiscal space to fight poverty. GOSL is on-track with the IMF Poverty Reduction Growth Facility (PRGF) program but implementation continues to be challenging.<sup>12</sup>

<sup>9</sup> [http://www.indexmundi.com/sierra\\_leone/demographics\\_profile.html](http://www.indexmundi.com/sierra_leone/demographics_profile.html)

<sup>10</sup> Joint EC/DFID Country Strategy Sierra Leone, 2008.

<sup>11</sup> Anti-Corruption Commission, Towards A Better Health Care Delivery System, Recommendations for Reform, 2009.

<sup>12</sup> IMF, Article IV Consultations, January 2009.

### **Social context**

With a GNI per capita estimated of US \$200, Sierra Leone remains one of the poorest countries in the world. 70% of the population lives below the poverty line, with a vast difference between Freetown and the rural areas (15% and 79% of the population living below the poverty line, respectively). It ranked 177th out of the 177 countries ranked in the World Human Development Report in all but one year for the past ten years. The 2003/04 household survey shows that 70 percent of the population lives below the poverty line of Le 2,111 (slightly below US\$1) per day.

Sierra Leone population is composed of a diverse number of ethnic groups with two dominant ethnic tribes (Temme (35%), Mende (31%) while an estimated 77% of the population are Islamic with 22% Christian and 1% other. (DHS, 2008). The population is predominantly rural (60%)

In terms of public services other than health, the government of Sierra Leone has taken steps to ensure that all children access quality primary schooling. However, 30% of the children of primary school-going age are still out of school. Causes of non attendance include hidden and indirect costs, cultural barriers to girl-child education, child labour and lack of nearby schools (PRSP-II). Sixty per cent of the population – 50 percent of men and 70 per cent of women are illiterate<sup>13</sup>.

### **Meeting the Health MDGs**

As evidenced by Table 1 above, Sierra Leone is currently not on track to meet any of the health related MDGs by 2015.

**Table 1. Sierra Leone and the health related MDGs**

<b>MDG</b>	<b>2005 level (MICS3)</b>	<b>2008 level (DHS)</b>	<b>Target 2015</b>
Reduce Child mortality	Under- fives mortality rate: 286 per 1,000 live births	Under-fives mortality rate: 140 per 1,000 live births	Under- fives mortality rate: 95per 1,000 live births
Reduce Maternal Mortality	Maternal mortality ratio: 1,300/1000,000 live births	Maternal mortality ratio: 857/100,000/ live births	Maternal mortality ratio: 600/1000,000 live births
Reduce incidence of malaria and other communicable diseases	Malaria-under fives sleeping under insecticide-treated nets: 5%  Fully immunized children (12-24 months): 54%	Malaria-under fives sleeping under insecticide-treated nets: 25%  Fully immunized children (12-24 months): 40%	Malaria- Under fives sleeping under insecticide-treated nets: 75%:  Fully immunized children (12-24 months): 90%

The average life expectancy is 42 years. The maternal mortality ratio is reported to be 857 per 100,000 live births, (DHS, 2008), while other sources

<sup>13</sup> <http://www.regeringen.se/content/1/c6/12/33/46/8ebb8523.pdf>

suggest that it's likely to be significantly higher given proxy measures of facility based deaths. Despite the surprisingly high ANC attendance of 87% (DHS, 2008), only 42% of the women are assisted by a skilled health worker during the delivery and 25% delivers in a health institution. Fertility rate is currently 5.1 with a contraceptive prevalence rate among married women of 8%. Among the adult population, prevalence of tuberculosis is (847 per 100.000) and malaria is high, causing 3% and 7% of all deaths, respectively. The Prevalence of HIV in the general population increased from 0.9% in 2002 to 1.53% in 2005 and appears to have stagnated.

Infant and child mortality remain high, with infant mortality reported at 89/1000 and current under five mortality at 140/1000, thus giving a child up to five years a chance of survival of one in seven. EPI as a measure of public health performance is low with only 40% of children (12-23 months) having full vaccination (DHS, 2008). The nutritional status of children is cause for concern with 36% of children (<5 years) stunted indicating a chronic malnutrition situation, while 10% of children having wasting and 76% of all children having anaemia which is a major public health concern (WHO, 2008).

### 3.2 Revenues trends

Public health care in Sierra Leone is financed by domestic revenues (from the government consolidated fund and user charges) and external aid resources from donors.

#### 1. Domestic revenues

Domestic tax and non-tax revenue collection, which is put into the consolidated fund, as share of GDP has steadily increased in real terms since 2002 but with a 10.8% in 2007 was much below the average of 18% in other Sub-Saharan African (SSA) countries.<sup>14</sup> Domestic revenue collection was weak in 2007, due to underperforming collection efforts across revenue departments, uncertainties created by the 2007 election process; and the adverse impact of the international energy crunch on corporate profits.<sup>15</sup>

*Cost recovery* refers to full or part charging for services and medical supplies which constitutes a major part of the income for health facilities (whether formal or informal). In the case of Sierra Leone the target was 80% but later revised to 40%<sup>16</sup>. Local health facilities are permitted to retain 60% of the revenue raised from sale of medicines and remit the remainder to the district. There are two major challenges in this context. First, an efficient system of drug procurement and distribution is vital for this system to work. Secondly, vulnerable groups like, elderly, pregnant women and children under 5 are officially exempt from medical supply charges but many of those qualifying for exemption are regularly being charged for health service provision because of the limited revenue at local health facilities. A recent study indicated that less than 10% of clinics reported giving free health care to those groups.<sup>17</sup> There is currently no country-wide fee guidance by the MoHS and districts are encouraged to set fees in consultation with local communities and consulting the Village Development Committees (VDCs) and City and District Councils<sup>18</sup>. But most often user fees are set by clinic staff with minor involvement of DHMT and VDCs.<sup>19</sup> Also, the requirement to return 10% of user fees to the GOSL consolidated funds takes place infrequently and revenues are retained at health

<sup>14</sup> IMF, Article IV Consultations, January 2009.

<sup>15</sup> OPM, Public Expenditure Review of the Health Sector in Sierra Leone, July 2008

<sup>16</sup> In 2002 a policy was developed that aimed for 80% cost recovery, 10% of which was to be returned to the treasury. The target was later revised downwards to 40%.

<sup>17</sup> IRCBP (2007). Primary Healthcare in Sierra Leone: Clinic Resources and Perceptions of Policy after One Year of Decentralization, June 2007. Freetown: IRCBP Evaluations Unit.

<sup>18</sup> Gibril, A., Kargbo, T., Leigh, B., & O'Connell, A. (2004). Sierra Leone Health Sector Review. Freetown: British Council.

<sup>19</sup> IRCBP (2007). Primary Healthcare in Sierra Leone: Clinic Resources and Perceptions of Policy after One Year of Decentralization, June 2007. Freetown: IRCBP Evaluations Unit.

facility level. Figures from the Internal Auditor show that since 2002 the amount of revenue transferred to the fund has moved sharply downwards.<sup>20</sup>

Health insurance is at an early stages of development throughout the country. There is some exploration of social insurance for formal workers by NASSIT. Community insurance is non-existent but there are a number of examples of community loan schemes that help communities to spread the care and transport costs.<sup>21</sup> In light of this, GOSL and development partners have started to identify sustainable health financing options for the future. Two studies have been undertaken so far, by ILO<sup>22</sup> and DFID<sup>23</sup>. Both studies raised the difficulty in balancing the objective to provide access to affordable health services by the poor & vulnerable while ensuring that sufficient revenues are raised to finance high-quality health services. Discussions by government and development partners are ongoing about the most suitable health financing strategy and options.

## **2. External revenues (donor aid)**

While Sierra Leone has been considered an “aid orphan” in the past, today it is a highly aid dependent country. Per capita aid amounted to \$67 in 2002 compared to, for example, \$16 in DRC and \$43 in Rwanda. In 2006, total annual Official Development Assistance (ODA) receipts amounted to roughly USD 360 million per annum according to OECD/DAC data. Bilateral aid accounted for 35%, multilateral aid for 40%, aid by UN agencies for 14%, vertical funds for 2% and aid by INGO for 9% in 2006. While bilateral aid has been on a decreasing trend, multilateral aid (with World Bank and the EC being the two largest multilateral donors) has become increasingly important. The number of significant bilateral donors is small. By far, the biggest donor is the United Kingdom (DFID) accounting for more than half of total bilateral aid to Sierra Leone, followed by Irish Aid (13%) and USAID (10%) in 2006.<sup>24</sup>

The share of donor support that is included in the government health budget totaled Le 29 billion in 2002 and Le 17 billion in 2006.<sup>25</sup> Thus, aid to the health sector amounts to about 78% of total public health spending.<sup>26</sup> There is however still quite a share of donor support including that of international NGOs which is off budget but unrecorded. A more detailed mapping of donor support to the health is not available, despite efforts of the MOFED DACO<sup>27</sup> and MoHS NGO/donor liaison office<sup>28</sup>. Broadly speaking however, the biggest donors are the multilateral donors (World Bank, ADB), as well as DFID and the Vertical Funds (e.g. Global Fund). GBS is also the second most important aid

<sup>20</sup> OPM, Public Expenditure Review of the Health Sector in Sierra Leone, July 2008.

<sup>21</sup> OPM, Review of Financing of Health in Sierra Leone and the development of policy options, July 2008.

<sup>22</sup> The ILO study reviewed the possibility of introducing an unitary national social health insurance scheme that should cover the whole population including the poor. There would be free health service provision at point of delivery and the costs of this scheme would be financed through a mixture of various tax and non-tax revenues with contributions from donors (ILO, Preliminary assessment of the health insurance options for Sierra Leone. 2008).

<sup>23</sup> The DFID study was undertaken by OPM and concluded that transition to lower cost services for the population is key and suggested to focus on a facility-based approach. As universal health care in Sierra Leone is not currently affordable, the study proposed to abolish user fees for certain groups at primary health care facility level (OPM, Review of Financing of health in Sierra Leone and the development of policy options, July 2008).

<sup>24</sup> MOEF DACO, Development Assistance Report 2006, Freetown.

<sup>25</sup> OPM, Public Expenditure Review of the Health Sector in Sierra Leone, July 2008.

<sup>26</sup> OPM, OPM, Public Expenditure Review of the Health Sector in Sierra Leone, July 2008.

<sup>27</sup> DACO is collecting sector specific aid data and recording those into the Development Assistance Database. As of now, there are 169 currently running projects included in the database worth USD 174 million committed vs USD 157 million disbursed. Most of these have a multi-year time horizon. The DAD can be accessed at: <http://dad.synisys.com/dadsierraleone/>

<sup>28</sup> The NGO/donor liaison office has started to undertake a development partner mapping as well but states that it was so far only able to record about 5% of all donor and NGO money due limited response by the development partners.

modality for the major bilateral and multilateral donors after project aid to Sierra Leone. In 2006, GBS totalled about 22% of total aid to Sierra Leone while accounting for 35% of DFID aid, 22% of World Bank aid, 36% of AfDB and 21% of EC aid.

As aid has increased to Sierra Leone's health sector over time, a number of challenges remain to the effectiveness with which aid is provided. The key problems relate to (i) the limited absorption capacity within the MoHS at central and peripheral levels to manage increased aid resources, (ii) high aid unpredictability, and (iii) gaps in improved harmonization and alignment. Gaps in skilled staff, effective human resource management, budgeting and management processes make it difficult for government to administer aid effectively. The decentralization process has added to the complexity of managing the health sector, with roles & responsibilities and capacity at sub-national levels still to be refined and strengthened. At the same time, volatility of aid to Sierra Leone is higher than that of the world's top 10 recipients of aid.<sup>29</sup> Especially, the disbursement of budget support resources has been highly unpredictable leading to significant shortfalls in government funding. GBS disbursements have at times been as low as 60% of commitments and as late as the fourth quarter of the recipient government fiscal year.<sup>30</sup> For the health sector, 2007 has particularly shown the damaging effects of unplanned shortfalls in aid on the spending in poverty reducing expenditures.<sup>31</sup> Moreover, in 2008 in the health sector, the World Bank had committed USD 23 million and DFID USD 16 million for 3 sectors (health, education, water & sanitation) with other donors such as the EC and Irish Aid likely to complement funding. But as of August 2009, these commitments had not yet materialised due to delays in setting up the pooled fund arrangements.

Overall, the difficulty in generating a comprehensive overview of aid to Sierra Leone's health sector is in part caused by a serious lack of financial information from development partners. Mapping of donor contributions is incomplete and financial information is provided irregularly. Donor aid is not included in the MoHS IFMIS records and there is high fragmentation of uncoordinated support from development partners at central and district level. The major traditional donors (EC, IDA, DFID, AfDB, Ireland Aid) provide quarterly reports on actual donor flows to DACO who is currently collating aid flow data into the newly designed Development Assistance Database (DAD). Information from UN and non-traditional donors such as China has not yet been comprehensively captured by the DAD. Donor coordination mechanisms are in their infancies and a very small share of aid to the health sector is actually using national PFM systems.

### 3.3 Expenditure Trends

Domestic public health spending in Sierra Leone is low compared to other African countries. The share of domestic health spending to total consolidated government spending has since the civil war totalled 5.3% in 2004, increasing to 6% in 2006 but decreasing in 2007 to 3.6%. Per capita health spending by the MoHS and local governments rose from USD 2.2 in 2004 to USD 3.1 in 2006 before decline to USD 1.6 in 2007.<sup>32</sup>

As domestic public health spending is low, Sierra Leone is highly dependent on external development partners funding to the health sector. In 2004, spending

<sup>29</sup> EURODAD (2008) Old Habits Die Hard; Mapping External Resource Flows to Sierra Leone.

<sup>30</sup> Canavan, A. Vergeer, P., Rothmann, I., A rethink on the use of aid mechanisms in health sector early recovery, 2008.

<sup>31</sup> OPM, Public Expenditure Review of the Health Sector in Sierra Leone, July 2008.

<sup>32</sup> OPM, Public Expenditure Review of the Health Sector in Sierra Leone, July 2008.

by external development partners as a share of total public health spending amounted to 83.2% declining to 78.1% in 2007. Per capita health spending by development partners included in the budget declined from USD 10.8 in 2004, to USD 6.9 in 2006 and USD 5.9 in 2007.<sup>33</sup> It should be noted however that there is a significant share of additional resources by donors that is not included in the budget. With a percentage of 6% in 2005 and 3.4% in 2007 to total government spending, total public spending on health in Sierra Leone is insufficient to meet the MDGs.

Private health spending is relatively high. The recently published National Health Accounts and the recent ILO and OPM study on health financing<sup>34</sup> confirm out of pocket spending dominate total health spending ranging at about 69%. The largest part is spent on drugs next to expenditures for travelling to the health facilities and user charges. Private pooled funding through insurance amounts to less than 1% of total private spending.<sup>35</sup>

By economic classification, about a third of the budget is allocated to salaries. They are more or less regularly and fully paid and have grown by 20% in real terms between 2004 and 2009. It should be noted that salaries for health workers in Sierra Leone are however significantly below the level of that in other African countries.<sup>36</sup> Non-salary recurrent expenditures accounted between 40% and 70% between 2004 and 2006 and are often being paid late in the year especially drug supplies. Negligible funds are spent by the government budget on investment both at central and district levels, with most development expenditure being financed by development partners.<sup>37</sup> By administrative classification, between 9 and 17% is spent at the central level on policy formulation and human resource management including training. The bulk of public health spending is used for primary health care, either at central level or district level.

A conclusive picture on the overall execution rate of the health budget is difficult to derive, but as the Public Expenditure Review (2008) highlights "it is worth observing that on average over the past four years only around 70% of the non-salary budget was actually allocated and spent"<sup>38</sup> and for the remaining expenditures serious delays throughout the year and shortfalls in actual disbursements occur. In 2009, the MoHSS reported that out of a budget of 34 billion Sierra Leones only 6 billion had arrived by July.<sup>39</sup>

<sup>33</sup> OPM, Public Expenditure Review of the Health Sector in Sierra Leone, July 2008.

<sup>34</sup>

<sup>35</sup> Government of Sierra Leone, Sierra Leone Integrated Household Survey, 2003-2004.

<sup>36</sup> OPM, Public Expenditure Review of the Health Sector in Sierra Leone, July 2008.

<sup>37</sup> E. Wylde, M. Schoch, A. Fölscher, RFP-IVCA-2007-002, Regional Study on the Reflection of Children's interests in PRSPs and Budgets in West and Central Africa, Case Study Sierra Leone, May 2009.

<sup>38</sup> OPM, Public Expenditure Review of the Health Sector in Sierra Leone, July 2008.

<sup>39</sup> Interview with Director of Primary Health Care, MoHS Sierra Leone, 15 July 2009.

**Table 2: Key public health expenditure (Sierra Leone 2004-07)**

	2004	2005	2006	2007
<i>Public health spending:</i>				
MoHSS	16.8%	17.9%	25.2%	21.2%
Local Government (%)	0.0%	1.8%	5.9%	0.7%
Development Partners (%)	83.2%	80.3%	68.9%	78.1%
Domestic spending as a proportion of total consolidated expenditure				
5.3%	6.0%	6.0%	3.6%	
<i>Spending per capita (US Dollars):</i>				
MoHSS	2.18	2.61	2.51	1.59
Local Government	-	0.26	0.59	0.05
Development Partners	10.78	11.70	6.88	5.86
Total	12.96	14.57	9.98	7.51
<u>By economic classification (%):</u>				
Salary	24%	34%	37%	58%
Non-Salary	73%	52%	54%	40%
Development	3%	4%	9%	2%
<u>By administrative classification (%):</u>				
Policy Formulation	<sup>40</sup> 17%	4%	9%	6%
Human Resource Management	0%	5%	3%	6%
PHC Programmes	9%	11%	11%	3%
District PHC Programmes	19%	13%	27%	7%
Secondary HC/District Hospitals	33%	35%	26%	54%
National Referral/Tertiary Hospitals & clinical/support services	22%	32%	24%	24%
Not categorised	0%	0%	0%	0%

*All data are based on OPM, Public expenditure review of the health sector in Sierra Leone, July 2008 which makes use of the IFMIS data.*

### 3.4 Decentralisation

Decentralization is described by Rodinelli (1994) as a process that involves one or all of the following aspects, (i) the shifting of workload from central to peripheral levels known as *deconcentration*, (ii) the transfer of management from the centre to semi-autonomous organizations and agencies known as *delegation* and (iii) the transfer of decision making and political powers and the authority for managing public services to independent elected local governments known as *devolution*.

In the case of Sierra Leone, devolution occurred following the Local Government Act of 2004 which mandates the transfer of funds and administrative power to local levels while the line Ministry remains responsible for policies and standard setting. As of 2005, primary health care (but not vertical programmes) – was decentralised to local councils. Block grants worth one quarter of the national health budget<sup>41</sup> have been allocated through the Local Government Finance Department directly to District Councils. From 2008 the responsibility for funding district hospitals, with the exception of those that act as referral centres from other districts (Bo, Makeni & Kenema), were officially devolved but delays have occurred in the management structures so this has not yet taken effect.

<sup>40</sup> Combined with Human Resource Management.

<sup>41</sup> In 2006, this accounted for 9.1 billion Leones (approximately 3.0 million US dollars).

In practice, Local Councils transfer the resources to the DHMT who plan the activities and manage the funds with varying degrees of supervision by the Local Council. Procurement and supply of drugs and payment of staff are still managed through the Ministry in Freetown.<sup>42</sup> Spending responsibilities refer primarily to non-salary, non-interest recurrent expenditures and cover activities such as vaccination campaigns, epidemic control, infrastructure improvements and expansion and the operational expenses of the District Health Management Team (DHMT). Salaries are still being paid by central government who retain full control over all hiring and firing of staff. The development budget of the MoHSS is negligible and investment expenditures at peripheral level are mostly financed by local development grants from government and by development partners.

<sup>42</sup> IRCBP, Primary Healthcare in Sierra Leone: Clinic Resources and Perceptions of Policy after One Year of Decentralization, June 2007.

## 4 Findings from Assessment of Key elements of SWAp

### 4.1 Government Leadership

**Table 3. Current status of Government Leadership**

SWAp Element	Criteria	Assessment (1-low; 2-medium; 3-high)
	<b>Overall</b>	<b>Medium</b>
Sound and sustained government leadership for the health sector development	Well articulated vision and mission for health sector growth	<b>Medium.</b> Leadership is now the first pillar of the new national health strategy with roles clearly delineated.
	Clear mapping of priorities and resources based on assessed needs	<b>Low (but sub-sector for RH is medium)</b> Competing and contradictory priorities between political and technical directives within the MoHS and other ministries
	Regulation, stewardship and good governance manifesting in improved health outcomes	<b>Low</b> Efforts towards improved regulation and accountability mechanisms have been challenged by changes in leadership and decentralization Shift from donor led approach to more ownership by the MoHS – at the early stages of its maturity. Effects on health outcomes not yet evident

Government leadership comprises of leadership capacity and ownership and is one of the core elements included in a sector wide approach; SWAp can foster development of leadership capacity by having improved dialogue and harmonization of management procedures between governments and donors (Shepard et al (2008)). The literature on leadership distinguishes between management skills (plan, budget, coordinate and monitor) and that of leadership which requires the ability to influence and build teams. Good leaders possess the ability to provide direction, support and standards for accomplishment, communication of a compelling vision, hiring and staffing strategically and to motivate teams (Hogan et al (2004)<sup>43</sup>). The Sierra Leone draft National Health strategy has dedicated one of its six pillars to leadership and governance which is described as “Leadership and governance encompass policy guidance, regulations, monitoring and oversight, collaboration and coalition building, accountability and external partners”. While recognising the importance of its role as regulator and coordinator, it also recognises that there are major gaps in their institutional capabilities in relation to all of the key roles identified. The needs analysis as written into the strategy reflects these gaps and is further explored here in the light of current challenges and opportunities that prevail.

It is acknowledged more widely in the literature in the context of leading health sector implementation that change of leadership brings its own challenges. New government decision makers need to gain experience, understand the sector processes and introduce their own ideas. Sierra Leone is currently witnessing this process, since the election of a new government in 2007 followed by a cabinet reshuffle and additional changes within the MoHS in 2008. For example, the appointment of a new CMO and PHC Director and a

<sup>43</sup> Hogan, R., Kaiser, R., 2004. What we know about leadership. APA/EPF journal. Assessment of readiness for a Sector Wide Approach for Health in Sierra Leone

newly instated RCH department in 2008 implies significant realignment of roles and vision for the respective areas of work. New strategic directions and innovative ideas are not always well received by the technical staff while there may exist a tension between political and technical priorities identified.

Effective government leadership will focus on priorities based on a good analysis and avoid unrealistic targets<sup>44</sup>. There is a need for strong government leadership in order to make this prioritization. It is evident that the MoHS faces both internal and external pressure from stakeholders to choose certain priorities. In practice, SWAps have often been more concerned with the general performance of mechanisms of planning and finance and efficiency of resource use; the quality of service delivery and equity in access has been secondary-level concerns. It is vital that the priorities in policy and programming are directly linked to the needs of the population and sequenced accordingly.

In 2008, the President introduced a performance based management for all line ministries, which calls for quarterly reporting against key performance indicators. Such approaches are results focused and stimulate greater upward accountability. However they do need to be consultative and engage with priorities laid out in the national health policies and strategies, there are indications where political priorities overshadow the technical plans that have been agreed. It is also evident that the voice of civil society has been excluded from the planning processes and ownership resides primarily in the hands of government. The decentralization efforts took limited cognisance of local power structures (EURODAD, 2008) whereby local, district chiefs were not included in the decision making processes that directly impact on their powers and support to their people.

While human resources are central to the success of any strategy, the structures and systems need to be in place for managers and staff to function effectively. The existing organogram for the MoHS requires restructuring based on the dual arrangement that splits the technical and administrative line management with few deputies to supervise and support the various technical departments. Equally the organogram has not yet taken account of the decentralization process and devolution of responsibilities from central to district level. Meanwhile there is no change management approach agreed to steer this process and guide the performance measures in relation to achieving the results.

With the internal complexity placing a heavy burden on the few senior managers within the MoHS, the external world of development partners also demands attention. The complex business of managing a health sector which is largely funded by donor aid creates challenges. Previous reviews have acclaimed that SWAps offer donors enhanced influence on policy, reform and evaluation, in the case of Sierra Leone, an estimated 78% of the health expenditure is accounted for by external aid which requires skills of negotiation, flexibility and openness to dialogue. The question of ownership comes into play whereby we draw on the RCH process as an illustration where the "drivers of change" and ultimate ownership resides. Concerns were raised regarding donor policies and practice including, threats to multi year funding commitments, lack of flexibility, and complexity of procurement procedures and lack of joint monitoring.

<sup>44</sup> Walford (2007). A review of health sector wide approaches in Africa. London: HLSP Institute.

Using the Brown et al model<sup>45</sup> of determining level of ownership it is evident that Sierra Leone fits into the model which suggests that “the government change agents use their alliance with donors to drive through a sector policy and program despite opposition”. Indeed Sierra Leone has shifted in the recent years (from 2005) from a donor leadership model to increasing ownership and the MoHS as initiator of the process but it is still at the very early stages of this process. Challenges and risks clearly remain which threaten the commitment to government leadership.

### **Conclusions**

1. Leadership is now the first pillar of the national health strategic plan; leadership is a critical resource for steering and oversight of policy development, resource mobilization, shared processes and approaches and performance monitoring. A shift to increased government ownership is in evidence but alliances both within government and with development partners requires continued efforts. Equally, structures and support systems need to be strengthened to create an enabling environment for leader to do their job.
2. While the MoHS is perceived to be an equal partner in the development of the RCH strategy there is also a risk that the donors can overtake the process. As articulated in the draft national health strategy (2009) – ‘the opportunity for the Ministry to take the lead in consistently analyzing health priorities in the sector and deciding on resource allocation has often been subsumed by strategies and plans initiated by development partners’.
3. The word “trust” was mentioned by both MoHS and development partners as key to progress. Trust building however is a process that can only be reached through shared understanding and appreciation of the commitments made and how to reach them. Timely monitoring of progress and evidence based dialogue in the form of periodic and annual reviews were found to be one of the most important pre-requisites in the context of a sector wide approach. (Walford, 2007)
4. The structure of the MoHS where a separation of administrative and technical line management as prescribed by the organogram negatively influences the scope for joint management decision making and greater internal coherence across departments.
5. A threat to sustained institutional commitment arises whereby donors fund individual managers within the MoHS, with the risk of negating or undermining institutional ownership by the MoHS. If the funds are terminated or the senior manager leaves the post, rebuilding of the understanding and agreements will be required.
6. Development partners need to jointly support the process and sustain the efforts beyond the initial planning phase; in this case there is a major risk of donors reneging on commitments and re-defining priorities outside of the strategy agreed.

<sup>45</sup> Brown, A., Foster, M., Norton, A., Naschold, F., 2001. The Status of Sector Wide Approaches. Centre for Aid and Public Expenditure. Working paper 142 ODI

## 4.2 Sector policy

Sector Wide policies are one of the key elements of a SWAp and is defined by a policy framework that links strategic analysis with decisions about resource allocation. It defines sector goals and objectives, a national health policy and strategy as well as sub-sector policies. It further defines roles of public and private sector in the financing and provision of health care, identifies the policy instruments and set out the institutional arrangements that will be required to achieve sectoral objectives. This should include an agenda for capacity building and institutional development and provide guidance for prioritizing government and donor expenditures, within the overall public and private envelope. Policy development is analysed as shown in Table 4, in terms of the current status and how it fits within a sector wide framework;

**Table 4. Current status of Sierra Leone health policy framework**

SWAp Element	Criteria	Assessment (1-low; 2-medium; 3-high)
	<b>Overall</b>	<b>Medium</b>
A clear nationally-owned sector policy and strategy, derived from broad-based stakeholder consultation	Government owned	<b>Medium.</b> There are mixed experiences in who initiated the process and who drives the priorities. Insufficient consultation with civil society with a focus on state level "ownership". RCH strategy set a precedent for wider consultation processes – at the planning stage NHSSP was led by the MoHS and select agencies but slow to broaden the consultation process Decentralization has met with mixed results but has enhanced the control of resources and decision making by district councils
	Alignment of donor support with sector policy and aligned with MDGs/PRS	<b>Medium</b> There is growing policy coherence of the sector policy objectives with PRSP and MDG levels which will require continued translation in the form of results based prioritisation.
	Sufficiently pro-poor	<b>Medium</b> No in-depth poverty analysis underlying the policy framework. The RCH strategy has identified pro-poor priorities but not yet the means to achieve them. Pro-poor monitoring is only through the Public Expenditure Tracking surveys to date.

### ***Government ownership and alignment of sector priorities***

The Ministry of Health of Sierra Leone has a policy framework that consists of overall health policies and strategies as well as sub-sectoral policies, strategies and protocols. The National Health policy (2002), the RCH Strategy (2008) and the recently drafted national health strategy (2009) form the core framework documents. The National Health Policy (2002) 'sets the scene' for the health sector by recognising the importance of a primary healthcare approach with

priority to preventive, curative and rehabilitative services indicated. The policy acknowledges that a systems approach is critical to reaching the goal of health for all, with the three year rolling plans articulating the year by year priorities and steps for service delivery.

The development of a comprehensive RCH strategy (2008-2011) proved to be one of the more in-depth analytical processes of the MoHS, with its aim to accelerate improvement in delivery of reproductive and child health services<sup>46</sup>. It states the need to balance service delivery and systems development in order to reach the full attainment of the stated goals. Reservations were expressed by international agencies through an RCH appraisal process<sup>47</sup> on "the lack of integration of RCH priorities into a broader essential health services package and the lack of flow and alignment between strategies, objectives and indicators". Internally, the MoHS is also aware of the potential 'verticalisation' at program level, and the gaps in resources to roll out the strategy, as the cost estimates far exceed the total current health budget. The institutional and organizational dimensions that are missing in order to implement this strategy are clearly expressed in the capacity assessment document (Eldon et al, 2008).

The National Health Sector Strategic Plan (2010- 2015) was initiated by the MoHS in 2008 with technical support for its development from WHO consultants. It is intended to provide the framework that will guide the health sector directions and anchor the RCH strategy and other sub-sector programmes into one framework. The strategy is based on six key pillars of the health system, namely: (1) leadership and governance, (2) service delivery, (3) human resources for health, (4) Medical products and technologies, (5) healthcare financing, and (6) health information systems. These pillars will serve to guide decentralized financial and technical resources in order to address major diseases and contribute to the overall health status of the population. The strategy advises on improvements to the institutional arrangements for more efficient, effective and equitable health services. They include establishment of a Health Services Commission and a National health insurance scheme in the longer term. The first draft was confined to a core group but the second draft invited select consultation, while it is anticipated that the costing of the strategy and accompanying M&E framework will be developed by August 2009. It is premature to identify whether there will be collective 'buy in' to this strategy, as many donors and NGOs interviewed indicated that they had not had time to study the strategy due to restricted and late dissemination.

Historically, health policy development and its translation into implementation relied on external consultants, thus each event was independent of others, creating lack of coherence across the various technical policies and strategies. Most notably, references to other policy documents are limited and the nomenclature differs between documents. For example, in the National Health Sector Strategic Plan, there is only one reference made to the RCH strategic plan with a different set of objectives to achieve the goal of improved mother and child health. The vertical program documents state their objectives and plans, but the MoHS is not sufficiently explicit on the 'how' of integration of plans supported by the Global Fund or by GAVI. Streamlining and improved linkages of the various strategies would decrease risk of fragmentation and duplication for both the resource allocation and implementation level. The National Health Policy Advisory committee was established in 2008 to provide

<sup>46</sup> The Reproductive and Child Health (RCH) Strategic Plan (2008-2010) addresses priority maternal, newborn and child health interventions including a focus on youth, family planning and nutritional services.

<sup>47</sup> Reproductive and child health programme. Appraisal of programme strategy and implementation plan by development partners (May 2008)

policy oversight and direction thus intending in the future to minimise the risks indicated here.

Overall, there is potential for greater alignment of development partners with the health policies and strategies; this is evolving as Sierra Leone witnesses a major shift from independent project driven approaches to a more coherent developmental approach, but this will continue to require sustained commitments by all stakeholders. However, there are gaps in its articulation on the role of civil society and community participation in health and the role of public private partnerships in terms of their respective roles and responsibilities and guidance on how this will be achieved.

The MoHS with support from development partners have made strides in evolving the policy framework in the past two years. The priorities are largely in line with the major needs of the population as defined by baseline data measured in the MICS (2005), the DHS (2008) and by qualitative needs assessments. The resource gap in supporting the delivery of both the RCH and national health strategy is evident with limited commitments from donors for multi year support to date; this will be explored further under the budget analysis section.

### ***Poverty focus of sector policies***

The pro-poor poverty analysis informs the overall prioritization and equitable allocation of resources. SWAps were not designed specifically to enhance the inclusion of the poor; however, they were expected to support a sector policy consistent with the country's Poverty Reduction Strategy. In the sector wide policy there should be a strong link between those two strategies (Shepherd et al, 2008). Sierra Leone has not carried out a poverty analysis although several seminal documents (PRSP, formative assessments) are explicit about the extraordinary levels of poverty which prevail, with over 70% of the population living below the poverty line.

The PRSP does not touch on specific pro-poor issues and these are not addressed sufficiently in the PRSP II document. The need to be responsive to the poor is however recognised explicitly by the RCH Strategy which lists nine distinct barriers to accessing care: women's socio-economic status, children and adolescents (special needs of), distance and physical access, cost, quality, poorly staffed facilities, ill-equipped facilities, communication, inability to recognise danger signs in the mother/neonate<sup>48</sup>. In order to be responsive to the poor, all of these elements require attention. There are insufficient links between the sub-sector policy and strategy documents and the approaches recommended for health financing. So far, tracking pro-poor expenditure only occurs through the Public Expenditure Tracking Survey where CSOs have become involved in order to represent the 'voices of the community' and advocate for increased efficiency in resource allocations.

### ***Status of the decentralization policy***

*"For a SWAp implementation, the national level would like to have full regulatory authority. National level have not evolved, the districts have, the question is now who is supervising who". (UN representative)*

Improvements are noted in overall management at district level aided by the decentralization process whereby increased financial and technical resources has invigorated the district level structures (Councils, DHMTs, PHUs). Reference

<sup>48</sup> GOSL MoHS, RCH Strategy 2008-2010, Freetown, 2008, p. 23-25.

is thereby made in many reviews (IRCB review, 2008. Eldon et al, 2008) to the renewed access to resources, availability of approved workplans, local level procurement of drugs and supplies and expansion of the health infrastructure. In reality, the whole process of decentralization is still nascent with new institutional structures and new appointees at the helm.

Overall, results of decentralisation of health services to local councils have been mixed. Systematic evidence is limited with very few studies tracing the effects of decentralisation on health service delivery. IRCB (2009) reviewed the state of primary health care and are positive about the increase in PHU infrastructure. They indicate that decentralisation has benefited health care service delivery with some improvements in access to and quality of health services most notably, improvements in coverage, availability of drugs, and numbers of staff. Therefore there are still major gaps in capacities and shortfalls in resources based on needs. The greatest gap is evident at the district hospital levels with a difficult transition in line with the second phase of decentralization. Clearly with lack of adequate funding for secondary healthcare, these hospitals cannot function.

Local council officials reported that actual spending on health was only 10% in contrast to the 33% budgeted and funds tend to arrive late in the year, leading to rushed spending and allocation not in favour of priority areas. Also planning, budgeting and procurement capacity remains weak at district level as elaborated in, "Institutional and management capacity assessment for Sierra Leone". (Eldon, J. et al (2008). Key informants pointed to the possibility of a premature decentralization process which did not acknowledge the major deficits in central level capacities for regulation, governance and overall productivity, while expecting that the periphery could take care of devolved responsibilities. Meanwhile, at district level the accelerated processes as supported by World Bank and other donors did not allow for sufficient investment in capacity development with a notable absence of a solid capacity building plan to accompany the decentralization process.

### **Conclusions**

1. The health strategies and policies have coherence with the PRSP II which specifies the major health goals that will require dedicated multi year resources if the MDGs are to be realized.
2. Major milestones have been reached in relation to development of national level policies and strategies. There is still room for improvement in dissemination and translation of policy implications into clearly defined strategic directions in line with resources available. The vacuum in measurement of policy impact is notable and requires a more results focused approach to how the policies translate into improved sector performance and health outcomes.
3. The new PRSP II stipulates the need to move towards meeting the health MDGs. Clearly Sierra Leone will not meet the global targets but the monitoring process needs to be harmonised across stakeholders and link more directly with the health sector monitoring of the goals.
4. The national RCH strategy has potential to become the lead sub-sector strategy which can also be instrumental in supporting wider health systems strengthening. The strategy is highly ambitious in its timeline and resource estimations and success will be contingent on acceleration of donor commitments and adoption of the institutional arrangements as specified in the capacity assessment documents.

5. Gaps in the NHSSP include the role of civil society and representation in health, the approach to building up public private partnerships – which is acknowledged but not as a major area for development.
6. Pro poor analysis is weak at all levels – there are no socio-economic baselines but to date evidence points to very poor access to basic services. For monitoring purposes, reliance is uniquely on the public expenditure tracking (PETS).

### 4.3 Sector Budget

A second major element of a SWAp is the sector budget because it is through the budget process that the sector policy gets translated into implementation. The sector budget should reflect sector priorities and strategies, embrace all resources for the sector and do this preferably in a realistic medium-term perspective. Key to this is a planning & budgeting process that supports the development of a coherent national approach to medium-term sector expenditure planning with focus on reaching the poor. In this context, the various criteria for meeting SWAp budget support benchmarks are analysed.

**Table 5. Current status of Sierra Leone health sector budget**

SWAp Element	Criteria	Assessment (1-low; 2-medium; 3-high)
	<b>Overall</b>	<b>Low.</b>
A (medium term) budget & expenditure framework which reflects the sector policy;	Consistency of policy with budget allocations & actual spending	<b>Medium.</b> Sectoral budget allocations and spending partially reflect sectoral priorities and PRSP priorities.
	Existence of a supporting (multi-annual) budgeting process/MTEF	<b>Medium.</b> There is an orderly budget process in place and the MTEF fulfils basic functions of multiannual expenditure planning, but strategic planning is undermined by a number of factors (i.e. budget incomprehensiveness, unpredictability, etc.)
	Well-resourced: sufficient domestic and external financing available	<b>Low.</b> The budget is not well resourced, because of large commitment/disbursement gaps by donors, large differences between costing of sectoral priorities and current spending capacity, limited absorption capacity and complex and lengthy procurement procedures. There is no overall strategy available yet for financing health sector priorities in a sustainable manner.
	Alignment & predictability of donor contributions	<b>Low.</b> Aid is generally aligned with PRSP and sector objectives but there is incomplete and infrequent information on aid by donors. Ability of donors and government to disburse aid on schedule is low both for project aid and general budget support.
	Access to service delivery by the poor.	<b>Low.</b> The poor & vulnerable tend to benefit less from to health service delivery. Out-of pocket expenditures are high and exemptions for the poor & vulnerable for paying for health services are partially observed.

### ***Translation of sector priorities into (multi-) annual budgets***

The key planning and resource allocation tool for translating health sector priorities into implementation is the Medium-term Rolling Plan & Budget (MTRP) which is based on the medium-term district development plans and the central level plans & budgets. The MTRP presents a three year rolling (on an annual basis) forecast of expenditures, however independent of the previous two budget years. All major sector policy priorities are covered by spending on interventions at central and peripheral level. The GOSL uses the economic and functional classification, but ultimately the process of developing programme-based budgets should provide the most important link between policy and spending allocations. At the peripheral level the main planning and budgeting instrument are the district development plans, where estimated costs for 2009-2011 reflect the major sector priorities. But, resources are almost evenly allocated across sector priorities, except for human resource development and infrastructure, and resources are forecasted to increase by 10% on a yearly basis across all spending categories. This indicates that districts are still using incremental budgeting techniques with little emphasis on strategic prioritisation.<sup>49</sup> Broadly speaking, sector (multi-) annual budget allocations reflect to some extent medium-term sector priorities, but the differences in budget presentation across different sources (e.g. MTRP, District Development Plans, IFMIS) hamper a thorough analysis.

### ***Financing of sector priorities***

Costing of the (sub-) sectoral strategies in health is limited, although the recent RCH Strategy has been fully costed. The MoHS also aims at costing its new National Health Strategic Plan. The RCH costing exercise highlighted that current total public health funding is far too low to deliver quality health services, while international levels of expenditure suggest that those countries with better health outcomes than Sierra Leone are spending a substantially higher proportion of GDP on health. The major bottleneck to implementation is that health system capacity to deliver services and to rapidly scale up interventions is insufficient. There is no overall MoHS strategy which outlines how health services can be financed in a sustainable manner, with implications for changed ways of mobilising domestic revenues and external donor support. The major difficulty is how to balance the objective to provide access to affordable health services by the poor & vulnerable while ensuring that sufficient and predictable (domestic & external) revenues are raised over the medium-term to finance quality health services.

### ***Access of the poor and vulnerable to health service delivery***

The Public Expenditure Review in Health 2009<sup>50</sup> reports that based on a benefit incidence analysis undertaken, the poorest quintile of the population utilises both primary and secondary care substantially less than those in higher income group. The poorest 20 percent benefit from around 14% of the spending. In contrast, the top 20 percent benefit from around 25% of spending. There is substantial evidence that cost is one of the main barriers to utilising medical services. Yet, finance is rarely the only deterrent to utilisation. The MoHS and development partners are currently looking into more detail at various health financing options.

### ***Planning and budgeting process in support of sector priorities implementation***

According to the recently undertaken PEFA (2008), there is a relatively orderly and timely budget calendar in place in Sierra Leone, both for the preparation of the MTEF and the annual budget as a combined process. But the current

<sup>49</sup> Ministry of Health and Sanitation, District Development Plan 2009-2011.

<sup>50</sup> OPM, Public Expenditure Review Health Sector, May 2009.

calendar could potentially benefit from the two improvements. First, the inclusion of a detailed macroeconomic scenario and second, earlier strategic discussions at line ministry level based on bottom up district planning & budget processes, as a precursor to the Budget Call Circular.

The overall government Budget document presents a three year rolling (on an annual basis) forecast of revenue and expenditures, and the deficit and its financing. However, the current Budget document is independent of the previous two budgets in that there is no reference to previous forecasts. Links between multi-year estimates and subsequent setting of annual budget ceilings are unclear and differences are not explained.<sup>51</sup> According to the PEFA assessment, Sierra Leone scores comparable to other African countries.<sup>52</sup>

Although the financial system is in place that would allow the consideration of a budget including all sources of funds, integrated budgeting is not yet taking place although this remains a key objective articulated in the MoHSS MTRP 2007-2009. Four key factors that undermine the full potential of the MTEF from becoming a true strategic planning & budgeting instrument including;

- *Limited picture on overall resource availability:* The MoHSS and district budgets are not fully comprehensive, as a large share of donor funding remains off-budget. As a proxy, the Paris Declaration Monitoring Survey 2008, indicated that on average only 54% of all aid is included in the overall government budget.<sup>53</sup>
- *Unpredictability of resources:* Disbursements of non-salary development expenditures from MOFED to the MoHSS and district councils often arrives late and falls short of budget allocations. Revenue mobilisation schemes from cost recovery and other user service fees are have broken down adding the unpredictability of funding the sector budget. The same is true for aid from development partners There are significant gaps between donor commitments and disbursements and high overall aid unpredictability.
- *Lack of financial information:* Information on development partner support is incomplete and irregular. The PEFA 2008<sup>54</sup> highlighted that financial information, including its completeness and timeliness, provided by the donors for budgeting and reporting on project and programme aid is seriously weak. Also sector budget information from different resources (e.g. MoHS MTRP, District Development Plans, IFMIS) differs and is not always comprehensive.
- *Weak capacities at district level:* The introduction of multi-annual district development plans as of 2009 is an important step towards improving bottom-up planning and budgeting. However, district level planning and budgeting seems to take place only after central level planning & budgeting is completed which compromises clear bottom-up budgeting processes. Also, the budget classifications used in the district development plans are not in line with the MoHSS MTRP and reporting on district's actual spending on primary and secondary health is in dire need for further capacity building. The effectiveness of multi-annual district level planning is further hampered by the fact that districts will only see this process useful once it will be reflected in timely and full disbursement of budget allocations. So far, actual budget disbursements to districts have tended to fall short of budgeted allocations.

## **Conclusions**

1. Sector (multi-) annual budget allocations reflect to some extent medium-term sector priorities.

<sup>51</sup> GOSL, PEFA, 2008.

<sup>52</sup> GOSL, PEFA, 2008.

<sup>53</sup> OECD/DAC, Sierra Leone Paris Declaration Monitoring Survey, 2008.

<sup>54</sup> GOSL, PEFA, 2008.

2. The MTRP fulfils the basic functions of multi-annual expenditure planning, but there are a number of factors that undermine true strategic planning & budgeting (e.g. limited resource availability, unpredictability of domestic and foreign resources, lack of financial information and weak capacity at district level).
3. The sector priorities are not well resourced. There is a partial understanding of resources required to finance sector priorities (thanks to recent RCH strategy costing), but current total public health funding is far too low to deliver quality health services. Current efforts to develop a health financing strategy have still to result in commonly shared vision and implementation.
4. The poor & vulnerable tend to benefit less from to health service delivery. Out-of pocket expenditures remain very high and exemptions for the poor & vulnerable for paying for health services are only partially observed.
5. Aid to the health sector is broadly aligned with sector priorities, but is highly unpredictable and fragmented at central and district level. Donor financial information is incomplete and irregular.

#### 4.4 Shared processes and approaches

The element of shared processes and approaches is directly aimed at shared planning, implementation and management of the sector strategy between the various actors in the sector. Central to this element and in line with the aid effectiveness agenda as laid out in Paris (2007) and revisited in Accra (2008) is that of harmonisation and alignment. Harmonization should be seen as the co-ordination and merging of processes, institutions and systems among aid agencies. The components of harmonization are threefold; establishing of common arrangements, simplifying procedures to reduce the burden on governments and sharing information to promote transparency and improved coordination. Alignment is development assistance coherence with and integration into the government systems and institutions of the receiving country. Alignment comprises of two elements; alignment with the government's agenda and relying on its systems (Balogun, 2005). We will examine the level of "aid effectiveness" in the health sector – based on these key criteria and analysis of the current status.

**Table 8. Current status of shared processes and approaches for Sierra Leone health sector**

SWAp Element	Criteria	Assessment (1-low; 2-medium; 3-high)
	<b>Overall</b>	<b>Low</b>
Shared processes and approaches for planning, implementing, managing the sector strategy;	Development assistance aligned with national plan	<b>Medium</b> Partial alignment has been achieved to national plans and strategies – but with clear scope for further strengthening.
	Well coordinated and harmonized support with common arrangements	<b>Low</b> Weak inter- ministerial and intra MoHS coordination and harmonisation. Harmonisation of procedures and systems is still poor. Coordination is growing but needs sustained efforts by all stakeholders.
	Stakeholder mapping within the sector with coordination mechanisms (government, donors, private sector, NGOs)	<b>Medium</b> Fragmented stakeholder mapping. Evolving inter-government/development partners coordination and communication –continued strengthening and harmonising required in moving to implementation and monitoring of the strategies. Technical coordination is gaining strength.
	Joint, comprehensive capacity building approach	<b>Low</b> . No capacity building plan in place with fragmented approach to technical cooperation

A defined institutional framework for a sector wide approach is not yet developed but is articulated within the new national health strategy<sup>55</sup> - "The Ministry will also be streamlining the reporting requirements of different stakeholders to enable it to coordinate different actors better and fulfil its oversight responsibility, and will be moving gradually toward adopting the Sector-Wide Approach". The institutional changes that are in progress towards this aim include; (a) improving the organization of the health sector (b) defining and enhancing relations between different institutions and (c) rethinking the way tasks and responsibilities are distributed. In order to assess the current status of institutional developments, three levels of functionality will be explored in terms of structures for communication and coordination, engagement in shared processes and way forward under the three major levels as follows;

- i. Inter and Intra Ministerial coordination (MoHSS, MoF, DACO, Local Gov)
- ii. Government and development partners coordination
- iii. Central – peripheral actors in support to decentralization.

#### ***(i) Inter Ministerial coordination***

In the past two years efforts were made to establish more coherence in planning and management of the health sector. However, inter ministerial coordination is still nascent given the restructuring with senior appointments of ministers and directors, in the wake of the newly elected government in 2007. In this context, the Development Aid Coordination office<sup>56</sup> is now under the auspices of the Ministry of Finance and tasked with regulation and oversight of multi-sectoral development aid to include, monitoring of aid flow and aid effectiveness in line with OECD –DAC Paris agenda. As yet the coordination with line ministries is immature with no harmonization of donor/NGO mapping or jointly led tracking of tracer health indicators for aid effectiveness. The donor/NGO liaison office has initially focused on the set up of a donor database, collating and reporting of tracer indicators for aid effectiveness and establishment of a code of conduct for donors. Ultimately it is envisaged that this central level body will enable improved alignment of expressed national priorities (eg, PRSP, MDGs) for government and development partners. Given that health is a tracer sector for global tracking of the Paris declaration, this is an opportunity to link with the MoHS as a key sector.

#### ***(ii) Coordination between government and inter/intra development partners***

The development of national level policies and strategies has taken place with renewed impetus over the past two years (see Section 2; Policy). The process for development of the RCH strategy is described as participatory by a range of health sector representatives whereby an ongoing consultative process was in place with broad consensus on the content. The more recent development of the draft national health strategy was however a more closed process whereby only a few key health sector actors were involved. Overall, MoHS strategic directions will require continued efforts in dissemination of the strategies and dialogue in the move towards implementation of these strategies.

In terms of external coordination for the health sector, streamlining engagement and monitoring of resource investment (financial and TA support) is under the auspices of the Donor/NGO liaison office within the Ministry

<sup>55</sup> National Health Sector Strategic Plan 2010 – 2015 -

<sup>56</sup> See Table 3 - DACO Monitoring of OECD/DAC Paris Monitoring Survey (2008)

Planning and Information department, in collaboration with other departments<sup>57</sup>. The major aim of the office is to interact strategically within the MoHS and externally with development partners for better application of the principles of alignment and harmonisation through improved coordination of MoHS and donor/NGO functions. Approval of existing and new projects and signing of MoUs is now established with a database used for tracking of approved projects. With two full time staff (funded by World Bank), gaps remain however in the capacity of this office to oversee, multi-lateral, bilateral, NGO and private sector investments and to institute effective grants management coordination across the sector.

In order to track the progress of the health sector, national health sector reviews and planning meetings are officially scheduled annually. The only health sector review report available was for 2004. In the context of the sector wide approach, reviews are used as an instrument to track implementation progress against jointly agreed performance targets and manage different information needs of development partners. There was no health sector review conducted for 2009 and notably limited reporting on aggregate results from health system interventions on both a quantitative and qualitative level.

Technical coordination is also one of the core functions of this unit whereby several committees have been set up under their jurisdiction including the National Health Task force. The *Health Sector Coordination Committee (HSCC)* is the highest level coordinating body with multi sector representation with a mandate for advice to policy development, coordination and resource mobilization for all health sector developments. Under its auspices, there are several commissions and technical working groups who report directly to this body<sup>58</sup>. In addition, more recent developments in line with Global Fund applications, the *Country Coordination Mechanisms for the Global Funds (CCM-GFATM)* was established followed by the sub-sector RCH strategy which called for the establishment of The *Interagency Coordinating Mechanism for the Reproductive and Child Health (ICCRCH)*. Both of these coordination mechanisms are chaired and reported by the Minister. Additionally the RCH strategic plan created sub-working groups for Planning & Training, Logistics, Monitoring & Evaluation and Health Communications.

The Health Sector Coordinating Committee is reported to be well attended but there are shortcomings in its strategic value. Based on reactions from various committee members, meetings are often limited to reading of minutes and information updates rather than addressing identified problems, bottlenecks and agreeing on solutions to overcome them. Gaps in availability of information on program resources and commitments by donors also hinders consensus on streamlining of activities. To illustrate here, while some milestones have been reached in relation to policy and planning, there appears to be a current lack of confidence between the MoHS and donors in terms of next steps and resource mobilization. This is primarily attributable to significant delays in release of funding for RCH and prolonged uncertainty regarding the choice of mechanisms and modalities for program budgeting. This has caused a hiatus in processes of negotiation and moving forward to actual service delivery for RCH over the past year. During this study, it continues to be a watershed.

<sup>57</sup> This office was originally set up in 2004 with support from the World Bank five year project which is slated to end in August 2009 – concerns are expressed about its future viability.

<sup>58</sup> These bodies include, but are not limited to: the National Health Financing Task Force; Pool Funding Steering Committee (Chair Minister of Health); the Health Coordinating Committee (HCC, permanent body – Chair CMO); The GAVI support Inter Coordinating Committee Meeting; the Working Group on Aid Mechanisms and the Project Coordination Team for implementation of the National Health Plan.

Meanwhile, development partners who support the health sector have monthly coordinating meetings with all health sector donors and two NGO representatives in attendance. This structure is intended to oversee the partner processes and harmonise the ways of working with the MoHS. Members acknowledged the need to shift from information sharing to strategic thinking with more emphasis on the 'how and with whom' rather than on the 'what is happening' level. Members also suggested the need to broaden the agenda to include decisions on how donors can complement each other more effectively, make choices on aid mechanisms and more effective monitoring of aid flows and outcomes. Overall, there is a need to forge alliances and shared vision among the development partners, with more engagement in joint decision making processes, moving to joint assessments and monitoring. A sector wide approach calls for harmonising of efforts and complementarity of approaches, the will to move forward was expressed by representatives of donors and NGOs, building of trust and commitment will be required to achieve it.

***(iii) Central – peripheral coordination in support to decentralization.***

*"District health planning based on realistic priority setting should become a joint activity of all stakeholders in the health sector, whereby joint ownership is enhanced". (NGO representative, July 2009)"*

With the advent of decentralization, planning and management functions for health service delivery have shifted whereby district government are responsible for receiving and deploying resources through local government. As discussed previously, growing autonomy of district level managers requires new structures and systems to accommodate the transfer of responsibilities to district councils. Central to effective decentralization is having clear lines of communication and coordination between central and district levels and across government and non-government agencies. While most representatives interviewed on the subject of decentralization were positive in highlighting the potential opportunities for more equitable distribution of resources and 'bringing accountability closer to the people'. They equally stated the threats that prevail due to weak capacities in financial and operational management, absence of an institutional framework and accountability both upstream to the central level and downstream to the communities they serve.

The establishment of a District Inter-agency Coordination Mechanism in all thirteen districts mandates responsibility to the district council for coordination and communications with all health partners including UN agencies, NGOs, traditional and key religious leaders, heads of civil society and the private sector as members in addition to representatives of line ministries such as the District Medical Officer of the DHMT. The districts engage primarily with NGOs, who support an estimated 60% of the health service delivery; however the issue of contraction of resources for project aid is having a major impact on the capacity of NGOs to survive. The districts have limited strategic interaction with the central level government and even less with the multilateral and bilateral agencies, thus have limited understanding of the aid architecture, resource flow and criteria for monitoring effective aid management. With the advent of the district planning process in 2008, this has shown potential for improving communication and coordination but will require leadership from the district level to steer it. Gaps in management functions at the district level will inevitably lead to gaps in resource allocation and prioritisation of the limited resources available.

## ***Institutional Capacity Development***

An institutional capacity framework for development of human resources is not yet developed. Capacity building is therefore fragmented, and there are variable levels and predictability of funding at central and district levels. The health sector has technical assistance initiatives supported by multiple donors including, WB, MLI, Bill Gates Foundation, ICBRP, DFID, WHO, ADB, UNFPA. Some of the initiatives such as the Institutional Capacity building reform program supported by World Bank and the Management Leadership Initiative supported by Gates Foundation are cross sector and have in fact minimal direct contribution for the health sector. Most of the efforts operate independent of each other with separate project management structures and diverse approaches to channelling the technical assistance<sup>59</sup>. The recent DFID supported institutional and management capacity assessment for RCH identifies weaknesses in key capacities for all major functions from stewardship to management and supervision, from coordination to planning and budgeting. Such deficits translate into weaknesses of operational systems and low delivery capacity at all levels (Eldon et al (2008)).

More recent efforts to reinvigorate the vision and direction of the MoHS manifested in the development of results focused management plan that articulates the sector priorities (2008-2010)<sup>60</sup>. None of the MoHS senior staff reflected on these documents as “guiding principles for improved management practice”. The major concerns in relation to immediate priorities focused on resolving the anticipated gaps due to withdrawal of World Bank funding for senior MoHS positions, improving the overall salary structure, reduction of the high number of voluntary health workers in the system coupled with stimulating the donor commitment to supporting health worker incentives.

Institutional capacities are directly linked to the quality and quantity of the health work force. The key gaps identified in the NHSSP in relation to human resource points to the lack of right size and right skill mix to delivery quality health services further exacerbated by lack of adequate training institutions to train the necessary cadres. Out of a total of 6,035 staff on the payroll, only 2,435 are in fact qualified. This is further compounded by high attrition of the limited pool of skilled staff and related poor conditions and incentive system for employees.

In short, the developments for human resource capacity building are lagging behind all of the other major strategic developments and will undoubtedly interrupt the progress of achieving the ambitious goals set out in the RCH and the wider NHSSP strategies

<sup>59</sup> For example, for PFM capacity in the health sector, World Bank through the IRCB and EC program are in place. In addition, there have been several trainings on procurement financed by ADB, WB, and UNFPA. ADB is also financing training of district staff (e.g. in health service planning, health systems management, finance & accounting). The Management Leadership (MLI) initiative targets senior managers, but mostly at central level.

<sup>60</sup> MoHS Human Resource development plan was first developed in 2004 (2004-08) with an update in 2008. This was based on a functional review of the MoHS in 2004. There has been no substantive human resource mapping undertaken since then while it is realized that major changes have occurred since the immediate post conflict phase.

## **Conclusions**

1. At the higher levels of government (MoF, DACO, Local Gov), coordination with line ministries is still at the early stages, for example there is as yet no harmonization of donor/NGO mapping or jointly led tracking of tracer health indicators for aid effectiveness. The slow pace of consensus building between the MoHS and DPs is marked by the lack of harmonization of efforts to map donor resource flow, this remains a major concern.
2. The basic institutional structures for the health sector are now in place both within the government and with development partners. However, the lack of a rigorous institutional framework with sustained oversight and leadership by the MoHS requires strengthening.
3. Partial alignment has been achieved on the level of national policies but gaps remain in the translation whereby there is limited coherence across the various program strategies and between the national strategies and district plans.
4. Limited internal capacities within the MoHS to plan and manage health sector reform measures but a positively new impetus for setting up of committees and working groups<sup>61</sup>. However, one of the major challenges identified by government and partners is the extraordinary amount of time dedicated to meetings which may compromise time for actual implementation and monitoring processes. Improved streamlining and harmonisation of objectives across technical committees and working groups is critical.
5. The limited aid resources currently available to the health sector means growing competition among NGOs who survive on year by year project aid. This results in continuation of fragmentation and lack of a coherent approach to health systems building across government and non-government entities.
6. There is no defined capacity development plan; deficits in both quantity and quality of staff at all levels exist. Current technical assistance is ad hoc and reliant on donor resources that are largely vertical in its approach.

<sup>61</sup> Based on the numbers of officially approved technical committees and working groups – there are a total of five health sector committees and ten working groups in operation.

#### 4.5 Performance Monitoring Framework

With regard to a sector wide approach, common management arrangements on performance monitoring comprises of a common annual performance review, shared performance indicators and measures to strengthen management capacity (Hutton, 2000). Monitoring, evaluation and research are critical elements to strengthening health systems and moving towards a sector wide approach. A variety of performance indicators should be chosen, reflecting progress in health access, equity, quality, effectiveness, and efficiency. This requires collection, analysis and interpretation of reliable health data, thus requiring revitalised health management information systems that will improve monitoring and accountability.

*There are three levels of information required to form a comprehensive approach to sector reform and moving towards a SWAp (Palmer, M. 2007).*

- (1) At the operational level – routine service data is required to analyse their own performance as service providers, workload, and resource and budget needs.
- (2) Monitoring of data for resource allocation – which occurs at district and central level – to include prioritisation and budget versus actual expenditure for all priority programs.
- (3) Monitoring of the sector as a whole – includes expenditures, utilization of funds, performance and implementation of policies. This level of monitoring usually culminates in an annual health sector review where the MoHS and development partners jointly review the sector wide performance.

**Table 9. Current status of a Performance Monitoring framework for the health sector.**

SWAp Element	Criteria	Assessment (1-low; 2-medium; 3-high)
	<b>Overall</b>	<b>Low.</b>
A sector performance framework monitoring against jointly agreed targets;	Results focused and monitorable framework for the health sector	No performance monitoring framework in place Limited aid tracking – need for greater standardisation Health service program monitoring is weak

Currently Sierra Leone does not have a performance monitoring framework, the level of monitoring is more reactive and ad hoc, usually based on donor requirements. It is therefore limited to two levels that are sub-sets of a comprehensive monitoring approach;

- (i) Aid effectiveness monitoring (with limited aid tracking)
- (ii) Health service program monitoring.

##### ***(i) Monitoring of overall aid effectiveness***

This is achieved through aggregating tracer indicators per sector to report on PRS, MDGS and DACO/OECD Paris monitoring – this is still in its infancy and requires roll out of support to sectors for selection of tracer indicators, standardized data collection and feedback on progress or gaps in progress. This work is primarily conducted by the MoF and DACO who collate the line ministry data and submit reports to the various global institutions. Based on a review of

the documents, there is limited coherence across the sectors to determine agreed priorities. The institutional arrangements for monitoring of financial and non-financial information is still ad hoc while the representatives from these offices reported major constraints in obtaining reliable and timely information from the sector level. The tracking of financial resources is addressed under PFM in this paper and highlights the major gaps between planning and budgeting in particular at district level. The primary focus within the health sector is on monitoring of project or vertical program activities with few districts adopting a comprehensive monitoring framework.

***(ii) Health service program monitoring.***

The current planning cycle of the MoHS involves a 3 year rolling plan (MTRP) with district annual plans reflecting priorities for health service delivery. In addition, the PIUs including Global Fund and ADB/UNFPA have separate planning cycles with independent monitoring.

As yet, there is no results focused and monitorable framework for health sector in Sierra Leone. It is planned to develop a comprehensive M&E framework in 2009 to accompany the national health strategic plan and in the interim the approach to monitoring of health system performance is very fragmented. However, the Sierra Leone Health Information Systems Strategic Plan 2007 - 2016 was developed based on an assessment of the HIS undertaken in 2006 by the MoHSS in collaboration with Health Metrics Network. An implementation plan for the HIS was written after the strategic plan and covers the period 2007 – 2010,

The advent of a new national health strategic plan proposes a monitoring framework which will be developed. Currently, the RCH strategy includes an M&E plan but concerns were expressed in the RCH appraisal document regarding the lack of harmonisation of HMIS and multiplicity of reporting systems at PHUs and hospitals. It is proposed to strengthen reporting and dissemination as part of the M&E component for the RCH Programme which will provide resource for strengthening HMIS, health facility and population based surveys and for operational research.

In terms of national oversight for M&E, currently the World Bank fund an M&E manager at central level who is responsible for oversight of the information collection, analysis and its application to planning. Capacities however are very limited at both central and district levels for monitoring of health data and use of reliable data to inform planning.

*The Health Metrics Network* have supported the piloting of a HMIS in selected districts since 2005 with installation of hardware and a software database at district offices. Results of such investments to date suggest that it is feasible train M&E officers at district level to input the data and produce aggregate reports. However, interviews with district health management teams in the pilot districts highlighted several limitations including (i) the standard for basic recording of patient attendance and morbidity at the peripheral health units is poor so the data is not guaranteed to be reliable in aggregate form (ii) only the M&E officer knows how to handle the database thus limiting the wider capacity building for HMIS and M&E (iii) the database requires maintenance which they are not trained to undertake and (iv) there are no further resources to scale up the project. Meanwhile, NGOs operating in the districts oversee the recording and reporting only within the health facilities they support, thus not a viable approach to building a district wide M&E system.

The recent RCH M&E component<sup>62</sup> states that “it has been developed within the framework of the MoHS planning, monitoring and evaluation programme so it is not a vertical but a systems approach to M&E”. While this is encouraging and much needed, there is still a risk that priority will be given to results that are MCH focused, with a further risk of isolating MCH from an essential package of health services that needs to be in place.

There is fragmentation at implementation & monitoring level due to lack of tools and processes for M&E. Recent developments have included decisions to support district health teams to develop their annual plans with selected indicators integrated in the plans. Without further technical assistance, monitoring of these annual plans will not be feasible as local level capacities are still lacking. International TA through the Institutional Reform and Capacity Building Program (IRCBP) is made available through regional and district level coaching but this is only provided on a demand basis for annual planning and is not a regular mentoring and inservice TA facility for the sector level. Districts (DHMTs) recognise that they lack the capacity to undertake comprehensive monitoring of health services.

Opportunities for alignment of M&E systems within the health sector are also undermined by vertical programs. For example, Global Fund has set up vertical monitoring systems for HIV/TB and Malaria with officers trained to collect the monthly data to satisfy the selected indicators. The representative for the Sierra Leone GFATM office indicated that they have been successful in reporting indicators at process and output level in line with the requirements. Meanwhile other Project Implementing Units (PIUs) include ADB/UNFPA Reproductive health to five districts (2008-2011) conducts separate reporting with dedicated procurement and finance officers employed. In addition, all of the PIUs conduct their independent reviews and evaluations whereby no joint reviews are conducted within the health sector to date.

### **Conclusions**

1. There is no comprehensive Performance monitoring framework for the health sector, but plans are in place for its development in line with the national health strategy (2010 – 2015). Sector tracer indicators are provided to DACO but there is no joint monitoring of indicators.
2. The fragmentation of monitoring is exacerbated by the growing presence of separate project implementing units – which all have their own planning cycles and monitoring frameworks – which are vertically set up and with staff trained only for this purpose.
3. The lack of appropriate tools and processes undermine any efforts to move to a more joined up approach to monitoring of key health indicators by districts and NGOs – currently the NGOs extrapolate from HMIS but have their independent reporting cycles and formats.
4. World Bank fund the national level M&E manager, with funds terminating in August 2009, this is a major threat to the institutional capacity of the MoHS to oversee M&E developments in future.
5. The baseline data is drawn from the five year impact/outcome measures based on the DHS and on UNICEF MICS surveys, However there is to date no intermediate measurement for health outcomes that can be conducted bi-annually or annually. Reliance on five year intervals for measurement is not appropriate to map the critical milestones for health.

<sup>62</sup> Reproductive and Child Health Strategic Plan (2008 – 2010), Monitoring and evaluation component. January 2008.

6. Under developed monitoring systems at central and district levels means that data quality is poor – while efforts to improve this need to go beyond the district office to the PHUs, to ensure that health worker capacities exist to record, collate, analyse and use data. Currently there is no capacity building plan to streamline resources with current TA inputs within existing program interventions. The RCH strategy indicates the need for a systems building approach while the national health strategy pillar for health information systems identifies the need to build efficient management information systems.

## 4.6 Public Financial Management

A good PFM system<sup>63</sup> ensures that policy priorities have a chance to be reflected in budget allocations. It promotes allocative efficiency, whereby resources are allocated according to sector priorities and away from wasteful and/or ineffective programmes. PFM stimulates efficiency gains (“value for money”) in public spending. It protects aggregate fiscal discipline, i.e. that actual expenditure is in line with the approved budget and does not exceed what the government can afford to spend in view of available resources. In the framework of a SWAp, it is important that PFM capacity is supportive of the implementation of the sector policy and budget. Development partners can promote this through supporting PFM capacity building and increasingly use national country PFM systems and more aligned aid modalities. Obviously, this is a balancing act between avoiding parallel implementation structures to mitigate fiduciary risks vis-a-vis enabling health systems strengthening.

**Table 6. Current status of PFM and implications for a health sector wide approach**

SWAp Element	Criteria	Assessment (1-low; 2-medium; 3-high)
	<b>Overall</b>	<b>Low.</b>
Commitment to move to greater reliance and to build government PFM and accountability systems	Aid using country PFM systems	<b>Low.</b> A small share of aid is using country PFM systems. Most aid is managed by parallel PIUs.
	Improved budget processes & allocation & operational efficiency	<b>Low.</b> The overall PFM systems are comparable to other SSA countries and show an improving trend. But at the health sector level significant PFM capacity building is still needed. The introduction of the MTEF, IFMIS and district development planning has started and brought about some improvements in the budget process and the allocation of resources.
	Use of (more aligned) aid modalities	<b>Low.</b> GOSL benefits from general budget support. Donors in health rely predominantly on project aid. But there are discussions underway to set up a pooled fund for supporting the RCH strategy.
	Contribution of aid modalities to health sector strengthening	<b>Low.</b> Some support to health systems strengthening has been provided by donors mostly in form of project aid (i.e. trainings, TA), but these efforts have been fragmented with uncertain effects on long-term capacity building. GBS has promoted overall PFM strengthening

<sup>63</sup> See for example, the Strengthened Approach to Supporting PFM reform, as articulated by the PEFA Secretariat: [www.pefa.org](http://www.pefa.org)

		and streamlining policy dialogue at central level, but with limited effects on the health sector (in financial and institutional terms).
	Predictability in the availability of funds for commitment of expenditures to Ministries, Departments and Agencies (MDAs)	<b>Low.</b> Resources from MOFED in particular salaries arrive relatively on time, however non-salary recurrent expenditures show significant delays. Aid by development partners is highly unpredictable.

### ***PFM capacity in Sierra Leone's health sector***

Since the end of the war, the GoSL has made significant progress in rebuilding and strengthening PFM systems in the Ministry of Finance and Economic Development with support from development partners. According to the most recent Public Expenditure Financial Accountability (PEFA) Assessment in 2007, Sierra Leone scores slightly above average compared to other countries in the region which is quite an achievement consider the very low starting point after the war.<sup>64</sup> The fact that four main donors (World Bank, DFID, EC and ADB) have supported Sierra Leone with GBS since 2001 confirms that donors have a reasonable confidence in GOSL commitment to PFM reform.

PFM capacity both at central and peripheral level in Sierra Leone's health sector is weak. This is due to a number of problems:

- *Lack of budget comprehensiveness, transparency and predictability.* As illustrated in section 4.2.4, there are serious concerns in this area. A large share of DP resources remains off-budget. Government & DP resources arrive late and often fall short of budget allocations. There are significant gaps between donor commitments and disbursements, and the cost recovery and user charge system has broken down limiting availability of internally-generated funds.
- *Weak strategic planning & budgeting process:* As illustrated earlier, the value of the MTRP to function as a tool for multi-annual strategic planning is undermined because (i) the MoHS has a limited picture on resource availability, predictability and use, (ii) current budget classifications allow only a limited analysis of policy-budget links, (iii) the split between recurrent and development budget, and (iv) budget & actual spending information deviates across different sources (e.g. MTRP, MOF, IFMIS).
- *Weak personnel & payroll management:* All GoSL payroll is maintained by the Establishment Secretariat (ESO). Despite the improvements brought through the integration of payroll accounts into the IFMIS system, there are still considerable concerns about the reliability of personnel information. Recent audits have shown that 63% of sample personnel files were not made available to auditors, and of the ones inspected only 38% had all the required documentation. Work is currently underway to clean up personnel files, with a focus on civil servants in education, health, agriculture and the ESO in the first phase.<sup>65</sup>

<sup>64</sup> GOSL, PEFA, December 2007.

<sup>65</sup> E. Wylde, M. Schoch, A. Fölscher, RFP-IVCA-2007-002, Regional Study on the Reflection of Children's interests in PRSPs and Budgets in West and Central Africa, Case Study Sierra Leone, May 2009.

- *Internal Audit function has improved significantly and further strengthening is needed especially at district level:* The Internal Audit function in the MoHS is well-established and viewed as one of the more effective amongst MDAs. The Ministry's internal audit department undertakes audits at district level and makes relevant reports available to the district councils but the process for dealing with such reports does not seem to be fully defined. The department undertakes compliance audits and occasionally value for money studies as special assignments. Internal audit functions at the district council still need to be further strengthened.
- *Weak capacity in procurement management:* The MoHS procurement capacity is weak and there is management interference in the procurement process. Coordination amongst various stakeholders is limited creating concerns as regards the management of drug supplies, including a lack of robust accounting systems, apparent inequitable distribution, leakage; absence of information about vulnerable beneficiaries, accuracy whether due process in procurement is adequately adhered to.<sup>66</sup>
- *Strengthening of the accounting function with the Local Government Finance Department:* the LGFD is part of the MOF and is responsible for transmitting the recurrent and development transfers directly to the district councils, and for consolidating budget and accounts information from the 13 districts. Given its crucial function in managing the finance to the district level, further PFM capacity building is needed in particular in the light of further donor support being allocated directly to the districts.

#### **Use of government PFM systems & aligned aid modalities**

There is evidence that donors use the MoHS PFM systems (budgeting, accounting, procurement, auditing) only to a very limited extent. A significant share of aid by development partners remains off-budget. All major donor programmes have established their separate Programme Implementation Units (PIUs) managing their projects separately, usually with separate finance & accounts & audit staff. Also, the envisaged implementation of the RCH Strategy will be undertaken through separate vertical management arrangements. Obviously, this promotes fragmentation and duplication and seriously undermines health sector capacity strengthening.

In 2008, under the auspices of DACO, Sierra Leone took part in the Monitoring of the Implementation of the Paris Declaration. Although, data included are incomplete and do not cover sector related information and hence need to be interpreted with care, they give a first indication on the use of PFM systems (see table below).

**Table 7: OECD/DAC Paris Monitoring Survey 2008**

<b>Paris Indicator</b>	<b>Status in Sierra Leone in 2007</b>
Are disbursements on schedule and recorded by government	35% of aid scheduled for disbursement were recorded by government
Are government budget estimates comprehensive and realistic in terms of aid	54% of all aid is included in the budget estimates of the government
How much aid is programme-based?	27%
How much aid uses country PFM systems?	20%

<sup>66</sup> OPM, Public Expenditure Review Health Sector, May 2009.

How much aid uses country procurement systems?	38%
How many PIUs are parallel to country structures?	2

Source: OECD DAC, 2008 Survey on Monitoring the Paris Declaration Sierra Leone, 2008.

Moreover, donors are not extensively using programme based approaches and more aligned aid modalities. Aid to the health sector is primarily through project aid. A pooled funded is envisaged to finance the RCH strategy.

### ***Contribution of aid modalities to health sector strengthening***

#### *Project aid & technical assistance*

There have been several donor programmes supporting the strengthening of PFM capacity in the health sector, but these need to be more coordinated, needs-based and linked with central level PFM reforms. For example, the introduction of the MTEF and IFMIS has been supported through the PFM reforms initiated at the central level, which were financed by the World Bank through the IRCB and EC programme support. In addition, there have been several trainings on procurement financed by ADB, WB, and UNFPA. ADB is also financing training of district staff (e.g. in health service planning, health systems management, finance & accounting). Through the Health Metrics Network of WHO assistance has been provided to develop Sierra Leone's Health Management Information System. Sierra Leone has also been selected as one of the countries to benefit from the Managerial Leadership Initiative for Global Health. Furthermore, under its multi-annual support programme, the World Bank has supported the MoHS for a number of years with the financing of the positions of the NGO/Donor liaison, the internal audit, M&E, procurement and the health economist, all of which will be terminated by end of August 2009. There is an urgent need to clarify between the MoHS and the World Bank and/or other donors how the anticipated capacity gaps will be addressed in order not to endanger the future reform process and implementation capacity across the MoHS.

#### *Budget support*

As was described in chapter 3, GBS has been a very important source of government financing, in particular of pro-poor expenditures, in the post-conflict period.<sup>67</sup> A detailed analysis of the financial effects of GBS on the health sector was outside the scope of the study, but broadly speaking GBS tends to have benefited relatively more other sectors like education and social security. In light of increasing GBS resources to Sierra Leone since 2004, education spending as percent of recurrent expenditures increased from 19.4% in 2000 to 22.5% in 2007, whereas health spending increased from 4.7% in 2000 to 8.3% in 2003 but then sharply decrease to 3.8% in 2007. While there has been no earmarking of GBS resources to the health sector, a senior MoHS representative explained this as follows:

*“GBS did not translate into action to reach our health sector objectives. The government assumes that many donors are supporting the sector and therefore GBS is not allocated to the health sector”. (Senior MoHS representative)*

<sup>67</sup> For a more detailed analysis of general budget support and its general effects for the wider GOSL policy, budget and spending, see also Canavan, A., Vergeer, P. and Rothmann, I., A rethink on the use of aid mechanisms in health sector early recovery, Netherlands Royal Tropical Institute, 2009.

Although GBS may not have contributed to health sector reform in financial terms, GBS conditionality has arguably kept closer scrutiny on certain health sector reforms. In 2007, the GBS performance assessment framework contained 9 out of the 31 indicators relating to the health sector, for most of which acceptable progress was made.<sup>68</sup> As of 2008, the number of health related GBS PAF conditions has been reduced to 2 indicators. Although the GBS performance assessment process cannot and should not replace sector policy dialogue processes, it needs to be coherently linked with reforms at sector level and the MoHS should be, where relevant, be included sufficiently in the health sector related policy dialogue evolving from the GBS operation. However, so far, the MoHS felt that it has not happened.

**Conclusions:**

1. The overall PFM system in the health sector is comparable to other SSA and capacity building commenced at MOF and sector level have kicked started a number of crucial initiatives (e.g. IFMIS, MTEF, district planning, etc).
2. Most aid is channelled through separate PIUs which manage projects through separate finance & accounts & audit procedures. Although this practice is in part determined by the high fiduciary risk environment, it has undermined aid effectiveness. The RCH strategy runs the risk through its vertical management arrangements to lead to further fragmentation and duplication undermining health systems strengthening.
3. As general budget support is an important aid modality in Sierra Leone and health sector related reforms are also included in the regular GBS performance monitoring process, engagement of the MoHS in the GBS policy dialogue could have exerted greater understanding of the health sector needs and appropriate reforms.
4. Donor support to PFM capacity building; PFM has not always been needs-based nor has it been coordinated across different interventions and wider central level PFM & civil service reform. There are gaps in defining appropriate exit strategies from long and significant support to major functions of the health sector, calling the sustainability of capacity building support into question. The World Bank support to 5 major PFM functions in the MoHS is a case in point.

<sup>68</sup> These indicators related to: ensuring that actual spending is more in line with budgets; a greater share of the health budget is allocated to of non-salary/non-interest recurrent expenditure; strengthening health systems by promoting the transparency & accountability (e.g. establishment of internal audit units, improving the health personnel records management, notices detailing the transfer of essential drugs and financial resources posted on hospital and health centre notice boards, undertaking regular perception of service delivery surveys and public expenditure tracking surveys); Promoting better access to drugs by ensuring that more essential drugs are being distributed by DMOs to the PHUs; Improving health service delivery outcomes (e.g. increased child DPT vaccination, reduction in undernourished children).

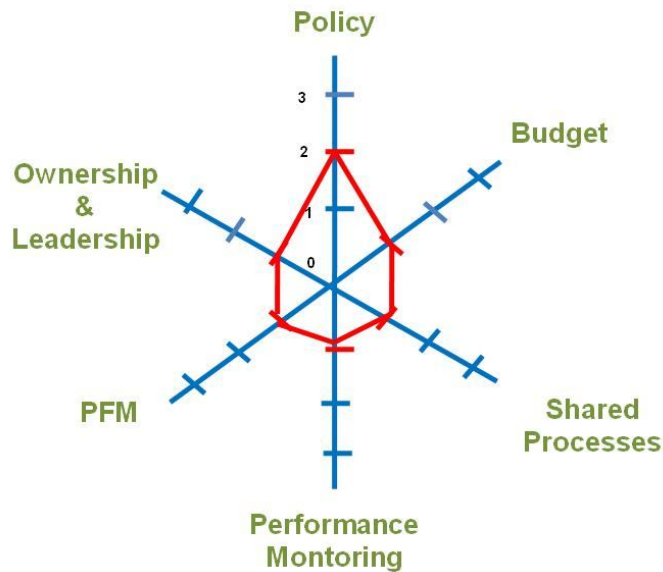
## 5 Conclusions and recommendations

Upon the withdrawal of UN peace keeping forces, the finalisation of the PRSP in 2005 and years of humanitarian support, Sierra Leone health sector has now entered a more stable, phase. This has led to various efforts to streamline policy, management and coordination arrangements in the sector that are also included within the framework of a sector wide approach. As defined in the introduction, SWAp is a process aiming at broadening government and national ownership over public sector policy and resource allocation decisions within the sector, increasing the coherence between policy, spending and results, and reducing transaction costs. SWAp can be supported by one or more sector programmes, which in turn can be financed by using different aid modalities (e.g. sector budget support, pooled funds, project aid).

This assessment to gauge the readiness of Sierra Leone health sector for introducing a SWAp has found that Sierra Leone meets the initial conditions in which sector programmes are more likely to be successful (*see Annex 2*). Based on the analysis of the six elements of a SWAp, Sierra Leone health sector is currently rates within the low – medium level (1-3 reflect the depth of the SWAp, where 1/low, 2/medium, and 3/high), for all of the critical elements as shown in Figure 2 below. On the subject of aid effectiveness, there are general efforts to promote greater harmonization & alignment through development of a national health strategy and sub-sector strategies. The move towards multi-donor budget support has been a welcome stimulus to promoting government ownership and a common platform for broad and systematic policy dialogue and facilitating joint monitoring efforts. Also the Joint EC/DFID Country Strategy is a valuable effort in promoting greater donor coordination. There are also plans by DACO to develop an overall aid policy which aims at outlining the government's strategy towards enhancing aid effectiveness and addressing these problems. However, many problems remain for the health sector, including a high fragmentation and duplication of donor support, lack of using government PFM and procurement systems and seeking joint approaches to analysis, programming, financing, implementation and monitoring. A large share of donor aid remains off-budget and the dominant modality is project and vertical funding. There is evidence that external funding for health care is unevenly distributed across the country, while GOSL funding tends to be more evenly distributed; particularly funds flowing to district councils follow a population-based formula.

Benefits of SWAps can only unfold once significant improvements are made in all six key building blocks and the cross-cutting issues such as capacity building and decentralisation become more aligned with the reform needs in the six SWAp elements. The spider diagram below illustrates graphically the existence of the key SWAp elements in Sierra Leone health sector (breadth) and the effectiveness with which these are being implemented (depth).

**Figure 2: Depth & breadth of the key SWAp elements in Sierra Leone health sector**



In concluding the state of readiness, a hierarchy is critical to prioritising and shaping the steps and sequencing of a SWAp; this requires internal planning and management by the government in collaboration with the development partners. Below we present our conclusions of the current status of the six elements and propose a number of priority recommendations which can function as a road map for the authorities and development partners in the health sector to improve policy, management and coordination arrangements.

### **1. GOVERNMENT LEADERSHIP**

Leadership is the critical cornerstone to a successful health sector and determines the level of national ownership through steering of shared processes and approaches. Based on analysis of the current leadership of Sierra Leone Ministry of Health, efforts to step up the leadership commitment are articulated as a primary function of the Ministry within the six pillars of the strategy. Attention is given to the role of stewardship and 'good enough' governance as key determinants which underlie national ownership. While efforts should now focus on building up synergy with the development partners and civil society, the vision and direction is not yet apparent. There is a need for strong government leadership in order to make focus on priorities based on good analysis thus avoiding unrealistic targets. Threats to this leadership can come from both within and from external partners as articulated in the draft national health strategy; 'the opportunity for the Ministry to take the lead in consistently analyzing health priorities in the sector and deciding on resource allocation has often been subsumed by strategies and plans initiated by development partners'.

Some of the factors that have been instrumental in creating a positive direction include the ambition and will of a few key technical staff within the Ministry, the opportunity for empowerment of the districts through the decentralized structures and the sustained efforts of NGOs to continue with service delivery

in the face of limited resources. Meanwhile, some constraining factors have emerged including; lack of sustained communications and coordination between government and development partners, tensions between political and technical priorities within the government and acute delays in allocation of committed resources. These events have undermined the trust and understanding that was cultivated throughout the original processes of strategy development and is vital for future success.

There is now a critical threshold which calls for stronger leadership from the Ministry and reciprocity between the ministry and donors; development partners need to jointly support the process and sustain the efforts beyond the initial planning phase; in this case there is a major risk of donors renegeing on commitments and re-defining priorities outside of the strategy agreed.

The following recommendations are made;

### ***Short-term***

- Structures and support systems need to be strengthened to create an enabling environment for leaders to do their job; Revise the MoHS organogram to foster greater collaboration straddling the technical and administrative arms of the ministry to enable departments eg, planning/finance, human resources/ vertical programs to gain even more coherence.
- MoHS leaders and key donors need to develop a technical cooperation strategy – currently ad hoc technical assistance is in place while individual managers are salaried by donors thereby compromising their institutional independence and integrity.

### ***Medium-term***

- MoHS to develop performance monitoring of the central and district level managers – which will enable them to function more effectively in their respective roles.
- Government and civil society need to improve transparency and accountability – with a two-way dialogue to strengthen health service governance.

## **2. A CLEAR NATIONALLY-OWNED SECTOR POLICY AND STRATEGY, DERIVED FROM BROAD-BASED STAKEHOLDER CONSULTATION AND WHICH IS SUPPORTED BY ALL SIGNIFICANT FUNDING AGENCIES;**

It is the role of the state to lead development of inclusive, participatory, comprehensive public policies and plans. The MoHS advanced its efforts in developing an overall health sector-wide strategy. The draft National Health Sector Strategic Plan (NHSSP) has the potential to play the role of anchoring the sub-sector strategies and plans into one realistic and coherent strategic framework. However, the buy in for this strategy is hampered by poor dissemination and limited dialogue across the sector stakeholder group. The NHSSP has potential to become the tool for full alignment of all development partners.

Although setting up large sector programmes usually takes a long time to get the right arrangements and processes in place, both government and donors have arguably not paid sufficient attention to setting out realistic timeframes for design and implementation of the NHSSP and the RCH programme. There has been insufficient thought for options of alternative, intermediary funding

arrangements to ensure the continuation of basic health service delivery. The mix of aid mechanisms to ensure concurrent service delivery with systems building in post conflict is vital in Sierra Leone context where it is evident that emergency health indicators exist and call for immediate funding of essential health services, eg, scale up of maternal and child health interventions.

Indeed, there is the opportunity for Sierra Leone health sector to now implement an approved RCH strategy. Since RCH is a key sectoral priority evidenced by weak MDG indicators, government and multi-donor support of the RCH strategy is likely to cover a major share of Sierra Leone health sector budget. However, there is the risk that the RCH support programme could be rolled out in a verticalised manner, thus undermining wider health systems strengthening and the integration with an essential package of health services. There is also the risk that the long design and approval process of the funding and management arrangements of the RCH programme have led to a break down in trust between MoHS and development partners.

The *decentralisation* of primary and secondary health services to the district councils has had some positive results in improving health service delivery, though access to health services remains very limited in light of high out of pocket expenditures. Limited attention seems to have gone to clarifying and delineating roles and responsibilities, and strengthening basic capacities both at the centre and the district level to ensure implementation.

The following recommendations are made;

#### **Short-term**

- MoHS with support from development partners need to take an active lead in dissemination and translation of policies and strategies in line with annual and multi annual planning.
- MoHS and development partners to develop a joint results framework for the sector and sub-sector strategies; that links with a comprehensive M&E framework for the health sector.
- MoHS RCH department to streamline approaches to implementation within the framework of the priority objectives; this will require rigorous monitoring and oversight by the RCH departments and donors.
- MoHS to revitalise the annual health sector review to discuss achievements and challenges in the health sector and derive coherent future strategic priorities.

#### **Medium-term**

- Civil society supported by NGOs to assume an active role in the decision making process for health sector development; more dialogue is needed to identify how community have a 'voice' in how resources for health are deployed and in feedback on the quality of healthcare they will receive.
- Pro poor analysis is weak at all levels; MoHS to improve tracking of the utilization of health facilities by the poor and financial burden on the poor due to high out of pocket expenditures.
- MoHS to lead with development partners to develop a capacity building strategy to strengthen health systems and coordinate diverse capacity building initiatives.

### **3. A (MEDIUM TERM) BUDGET & EXPENDITURE FRAMEWORK WHICH REFLECTS THE SECTOR POLICY**

A sector budget needs to mirror well the sector policy priorities and should embrace all resources for the sector, preferably in a realistic medium-term perspective. Key to this is a planning & budgeting process that supports the development of a coherent national approach to medium-term sector expenditure planning with focus on reaching the poor.

Budget allocations to health are well below other countries in the region and it is uncertain whether government allocations to health will increase in the future. Health seems to have been relatively neglected by GOSL assuming that it is a sector crowded by donors and NGOs, whose aid is largely off budget. In light of significant shortfalls in aid and lengthy bureaucratic process in disbursing government funds from MOFED, the health sector has faced serious overall shortfalls in funding undermining health service delivery.

The introduction of the MTRP is encouraging and has helped to align budget priorities with sector policy priorities, but it has not yet used its full potential in the fund allocation process, where problems with resource availability, predictability and information on resource use need to be addressed more strategically.

There is a now some understanding of the resources required to finance sector priorities thanks to the costing of the RCH strategy, but current total public health funding is far too low to deliver quality health services. Current efforts to develop a health financing strategy have still to result in commonly shared vision and implementation.

Pro poor spending is not meeting the PRSP promises. The poor and vulnerable benefit relatively less from health service delivery. Out-of pocket expenditures remain very high and exemptions for the poor & vulnerable for paying for health services are only partially observed. While access to health for the poor is key, financing options need to consider sustainable and availability of resources to finance high quality services. This impinges also on access to predictable and sustained donor financing.

Aid to the health sector is broadly aligned with sector priorities, but is highly unpredictable and fragmented at central and district level. Donor financial information is incomplete and irregular.

The following recommendations are made:

#### **Short-term**

- Map all donor/NGO support to the health sector and regularly update financial information every quarter. Coordinate with the DACO on the collection of data to avoid duplication.
- Bring aid on-budget (MTRP) and include data into the MoHS IFMIS as soon as possible to increase transparency.
- Cost the NHSSP.

#### **Medium-term**

- Clarify health financing options balancing pro-poor access to health services and availability of sustained funding.

- Improve predictability of donor funding by using multi-annual commitments and clarifying “criteria” for continuation of funding.
- Improve predictability of funding from MOF by supporting domestic revenue collection efforts and reducing bureaucracy in disbursements of funds to MDAs.
- Harmonise the way the budget /spending is presented in the MTRP, the MoHSS central level and district development plans.

#### **4. SHARED PROCESSES AND APPROACHES FOR PLANNING, IMPLEMENTING, MANAGING THE SECTOR STRATEGY**

Donors have historically undermined health service delivery and health systems strengthening by (i) working excessively through parallel implementation systems, (ii) creating gaps between aid commitments and disbursements, and (iii) providing infrequent and incomplete information on their activities at central and peripheral level. Although coordination structures are now in place, they are limited to information sharing and do not extend to strategic analysis and joint decision making.

There continues to be an imbalance whereby the MoHS perceive the strategic decisions on aid allocation to be donor driven, while the donors are waiting for decisions to be made by the MoHS – this results in a stalemate in final outcomes reached. Donors need to strengthen their own coordination and reach consensus on a common position and complementarity of the aid mechanisms to be deployed in consultation with the MoHS

While the inter-sectoral coordination is still fragmented, it undermines the opportunity for joint assessments by Ministries and development partners, joint monitoring of aid flow and equally more support for decentralization. Within the MoHS, the basic institutional structures have been set up to include high level committees, coordination groups and technical working groups. The terms of reference for the respective groups are highly ambitious; this is likely to also create unnecessary complexity. Clarification of the institutional framework with focused terms of reference is necessary.

Gaps remain in correspondence both within and across MoHS departments and with their supporting development partners. This calls for greater coherence in the translation of the strategies into action plans and agreement on concomitant human resources required. Concern over the limited capacities at both central and district level can only be solved through a streamlined approach to capacity development; currently there is no agreed capacity development plan which exacerbates the fragmentation and project based approach to services. Many of the current deficits cannot be fulfilled in the absence of appropriate TA inputs and having the right skills to fulfil the functions.

The following recommendations are made;

##### **Short-term**

- Coordination and communications between donors needs to move beyond information sharing to more strategic analysis and decision making processes.
- Development partners should assume a more proactive role in harmonising of aid tracking in consultation with the line ministries.

- More streamlining of committees and working groups to optimise the time spent in meetings and reduce the demand on implementing agencies and technical staff.
- Aid tracking to be conducted by MoHS with support and inputs from DACO and donors; this will help to improve tracking of gaps for priority interventions and improve resource allocation and aid predictability.

#### **Medium-term**

- Establishing of common arrangements, simplifying procedures to reduce the burden on governments and sharing information to promote transparency and improved coordination are still at the very early stages of development – this is a medium to long term goal to be reached.
- MoHS to assume a lead role in oversight of strategy (sub-sector) implementation, and forging alliances with development partners to ensure full alignment through regular dialogue, and joint monitoring for strategy implementation.

#### **5. A SECTOR PERFORMANCE FRAMEWORK MONITORING AGAINST JOINTLY AGREED TARGETS;**

There is no comprehensive performance monitoring framework for the health sector, but plans are in place for its development in line with the national health strategy (2010 – 2015). Sector tracer indicators are provided to DACO but there is no joint monitoring of indicators. World Bank fund the national level M&E manager, with funds terminating in August 2009, this is a major threat to the institutional capacity of the MoHS to oversee M&E developments in future.

The attention to monitoring of vertical programs and to NGO supported projects risks undermining the scope for a systems approach. Under developed monitoring systems at central and district levels means that data quality is poor – while efforts to improve this need to go beyond the district office to the PHUs, to ensure that health worker capacities exist to record, collate, analyse and use data.

The following recommendations are made;

#### **Short-term**

- Monitor the indicators of the Paris declaration at sector level in collaboration with DACO for reporting tracer health indicators.
- PIUs (Global Fund, ADB/UNFPA) should be invited to support wider capacity building for health systems monitoring purposes to include supervision support, capacities for data collection and analysis etc.
- More M&E tools are required, beyond the current DHS and MICS to ensure adequate monitoring of interim health performance at district and central levels. Donors should consider the complementarity of their support to M&E through harmonising of current assessment and monitoring arrangements.

#### **Medium-term**

- MoHS with development partner should develop a comprehensive Performance monitoring framework in line with the national health strategy (2010 – 2015).

- Aid tracking and monitoring of resource flows has commenced but standardisation of the tools is required.
- Health service monitoring relies uniquely on HMIS which is still weak with unreliable recording and collating of data at the health facility and district levels. Further strengthening through scale up of the current Health Metrics Network support is required.

## **6. COMMITMENT TO MOVE TO GREATER RELIANCE ON GOVERNMENT FINANCIAL MANAGEMENT SYSTEMS**

A good PFM system ensures that policy priorities have a chance to be reflected into budget allocations. Working through government systems allows to strengthening the ministry's leadership and ownership and the quality of national systems and capacities.

While the overall PFM system in the health sector is comparable to other SSA, donors have been perhaps too hesitant to using government systems. Most aid is channelled through separate PIUs, although the provision of general budget support to Sierra Leone indicates a certain confidence in PFM systems. The RCH strategy now bears the opportunity for more joint funding under a possible pooling of multi-donor funds, but its current vertical management arrangements run the risk to lead to further fragmentation and duplication undermining health systems strengthening.

The landscape of aid modalities in Sierra Leone health sector is quite uncommon for fragile states, benefiting from general budget support at the macro-level while project aid is the dominant modality at health sector level. The effects of general budget support on the health sector seem more limited and project aid, though ensuring most of the service delivery, has contributed to fragmentation. There seems to be a "missing-middle" for the health sector, where MoHS and development partners are only now considering aid modalities like sector budget support or pooled fund arrangements. These modalities have the potential to remedy many of the disadvantages of project aid. As health sector reforms are also part of the GBS performance monitoring process, greater engagement of the MoHS in the GBS policy debate could promote a wider understanding of the health sector needs and reforms. The GBS performance assessment process however does not replace regular sector review processes.

There is the need for greater coordination between the various PFM support initiatives to stimulate prioritisation and coherence. This includes greater coordination between central and sector level PFM support initiatives. There is only a small number of staff that have basic appropriate financial management skills in the MoHSS and at district level and expertise tends to be limited to a few senior level managers and hence capacity building support has to become more tailored to the national training needs.

The sustainability of the capacity building provided very much depends on the wider civil service conditions (financial and non-financial incentives). As long as these are not sufficiently attractive, it will be difficult to recruit and retain staff that has the necessary skills. A case in point is the World Bank support programme which financed 5 main PFM functions within the MoHS and whose support is likely to be terminated by end of August 2009. All staff has built important institutional memories and PFM capacity over time. There is an urgent need to clarify between the MoHS and the World Bank and/or other donors how the anticipated capacity gaps will be addressed in order not to

endanger the future reform process and implementation capacity across the MoHSS.

The following recommendations are made:

***Short-term***

- Take active part in the MDBS planning and review process to improve centre-sector level policy dialogue on health priorities and coherence with wider PFM/CSR reforms.
- Clarify as soon as possible how to address the capacity gaps arising from the ending of WB support to 5 key PFM functions in the MoHS.
- Speed up the discussions for more aligned aid modalities (e.g. pooled funding) in support of the implementation of the RCH programme.

***Medium-term***

- Step up capacity building support to PFM, in particular: planning & budgeting, accounting and internal audit both at central and decentral level. Without strengthening capacities at both levels, decentralisation is unlikely to be successful.
- Reduce the number of PIUs and explore which PFM systems can be relied upon for channelling of aid.
- Link and support central level PFM capacity building initiatives with health sector specific PFM capacity building.
- Clear the personnel files and payroll of ghost workers and double ditchers to free resources for the health sector.
- Strengthening the finance and accounting role of the LGFD in monitoring budget implementation at district level.

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## Annex 1. Contact List

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## Annex 2: Initial conditions in which sector programmes are more likely to be successful (based on Foster, 2004)

Circumstances where sector programmes are likely to be more successful	Application to Sierra Leone's health sector
Where public expenditure is major feature of the sector.	<b>Partly.</b> Public expenditure is low compared to high out of pocket expenditures, but a significant share of support from external development partners is not included in the budget.
Where donor contribution is large enough for coordination to be a problem, e.g. where aid accounts for more than 10% of GDP.	<b>Yes.</b> Donor contributions included in the budget account for roughly 80% of the public health budget and 5% of GDP. But there is a large share of support from external development partners that is not included in the budget.
Where there is a basic agreement on strategy between government and donors.	<b>Yes.</b> There is a basic agreement on the sub-sectoral strategy on promoting RCH, but agreement on the national health sector-wide strategic plan is currently discussed.
Where there is a supportive macroeconomic and budget environment to permit sector authorities to plan with reasonable confidence.	<b>Yes as regards the macroeconomic environment.</b> Sierra Leone's in on track with the IMF PRGF programme indicating relative macroeconomic stability. <b>Partly as regards the budget environment.</b> There is a MTEF in place promoting more strategic planning, but budget comprehensiveness, transparency and unpredictability remain a serious concern.
Where institutional relationships are manageable (e.g. single ministry, small group of donors)	<b>Partly.</b> There is one ministry in charge for the health sector tasked to ..... The district councils are the main implementer of primary and secondary health care. Although the decentralisation has shown some improvements in service delivery, access to services remains limited and the decentralisation process has added to the complexity of the reform process. The number of main donors in the health sector is small, but the number of international and local NGOs is high.
Where incentives are compatible with SWAp objectives (e.g. in light of civil service reforms)	<b>Yes.</b> There are no significant cuts in budgets & staffs foreseen as part of the civil service reform process, which may be incompatible with the increased responsibilities and needs for more coordinated health systems strengthening and service delivery sector. But the decentralisation process has added to the complexity of the reform process, although greater coherence between policies-spendings-results and coordination of development partner support would greater enhance capacity at district levels.

### Annex 3: Functioning of the Health Sector Coordination Committees

