# IHP+ 2016 MONITORING ROUND

# COUNTRY REPORT TEMPLATE

| COUNTRY | Sierra Leone |
|---|---|
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| DATE SUBMITTED | 11 April 2017 |

## 1 Process of the 2016 IHP+ Monitoring Round

The IHP+ focal point in Sierra Leone, the Chief Medical Officer (CMO) was contacted by IHP+ 2016 Monitoring Headquarters and agreed for the country to participate in this monitoring round. He delegated his responsibilities for the exercise to a senior Officer within the MoHS. A national expert was appointed to work with the MoHS for this process.

The delegated MoHS Focal Point liaised with the WHO and convened a meeting of the Health Development Partners forum with the DPs to explain the IHP+ 2016 Monitoring process, including data collection mechanisms, and obtained their concurrence to participate.

Following this initial meeting, the national expert, through the delegated Focal Point, contacted DPs and CSOs and sent them the necessary data collection tools for completion. Where necessary, the national expert made follow up contacts to enhance the completion and submission of the data collection tools. The WHO was very supportive and instrumental in this process, especially in facilitating cooperation between the MoHS and the national expert.

The Private Sector was not easy to contact, as this group did not seem to have a coordinating body, like SLANGO for the CSOs.

Of all those contacted and agreed to participate, Seven DPs and 15 CSOs completed (some of the DPs only partially) and returned their data collection tools. However, only three CSOs took the time to participate in the focus group discussion (FDG). Only one Private Sector representative appeared for the FGD, which was, therefore, cancelled.

The process did not move as smoothly as would be expected mainly due to competing priories, lack of commitment and leadership within the MoHS and the summer holiday period. This caused delays. With the support of WHO, an extended time was allowed for the process to continue beyond the originally scheduled period.

## 2 Commitment to establish strong health sector strategies which are jointly assessed and strengthen mutual accountability

### 2.1 EDC Practice 1: Partners support a single national health strategy

There is a National Health Sector Strategic Plan (NHSSP) 2015-18, which was developed by Government Ministries in collaboration with various departments and agencies.

This plan was assessed in 2015 through a "light" JANS with WHO support. Virtually all participants in this study reported that they did not participate in the joint assessment. They reported that, apart from the current assessment of the National Food and security implementation plan, no sub-sector assessment has been carried out. Even the Health sector Recovery Plan in response to Ebola has not yet been formally assessed

The assessment thus showed that there was a need for a more comprehensive assessment, including a review of sub-sector programme areas.

Indeed there are opportunities for strengthening the alignment of activities of partners with

the national plan and strategy as WHO plans to facilitate a joint assessment with well-defined goals and commitment of partners to participate and use the findings of this assessment in their funding decisions. Other areas of opportunity for this purpose include: 1) the implementation of the Service Level Agreements, a binding commitment that specifies activities, location and funding of activities carried out by partners; 2) Participation in coordinating MoHS structures such as the Health Sector Steering Committee, which includes the top level of MoHS, and the M&E Technical working groups.

During this monitoring process all DPs confirmed that their priorities are aligned with the national policies, and strategies.

## 2.2 EDC Practice 5: Mutual accountability is strengthened

The present M&E plan is outdated and it is used by the DPs in a limited way. Some DPs use the M&E national framework, others use different systems.

A new M&E plan is being developed by the MoHS with the support of DPs and is expected to be
ready in 2017. This is expected to improve its use by DPs. The M&E plan does not include mutual accountability, which is a principle of the COMPACT.

DPs support the development of this new M&E plan as they are aware that structures like IHPAU constitute a basis the M&E system can build on, and that that there is a high level commitment by the MoHS to ensure that the national HMIS will contribute to building a strong health information system.

In 2011 the Government, in collaboration with the DPs and selected CSOs, developed the country Compact, in accordance with the National Health Sector Strategic Plan (NHSSP) 2010-2015, to help strengthen the alignment of DPs with the Government for effective coordination around, and implementation of national health policies and strategies. The Private Sector was not included in this process. The implementation of this Compact remained, however, unfulfilled by both Government and the DPs, and the agreement is now outdated. Accordingly, it is being revised in line with the new strategic plan.

The Government conducts annual performance reviews. These reviews are not strictly JARs or MTRs, since major players in the health sector, such as DPs, CSOs, PS, and even representatives from Parliament do not participate.

This clearly hinders the process of mutual accountability. For this reason, the Government introduced meetings with their partners to track progress; these meetings were suspended during the Ebola outbreak .

In order to promote and strengthen mutual accountability, the Government is reported to have put in place specific mechanisms including capacity building of the MoHS staff for analytical reviews and judicious implementation of recommendations

# 3 Commitment to improve the financing, predictability and financial management of the health sector

## 3.1 Practice 2a/b: Health Development Cooperation is more predictable

The Government reported to have over-disbursed its health budget as a result of the response to the Ebola outbreak in 2014.This outbreak also brought in substantial aid from partners to strengthen national capacity for HS, surveillance, emergency preparedness & response, and HRH.
The Government has information that some DPs report their expenditure for health projects for a 3 year period.
Some DPs, however reported under-disbursement funds as they reprogrammed development funds to the Ebola response. One agency has requested an absorption capacity assessment for DPs to be able to determine the extent of their disbursement, to guide them adjust funding to their absorption capacity.
With respect to information on the period for disbursement of funds, two DPs reported that they had provided the government with information for 3 years (2016-17-18) and one for 2 years (2016-17). The DPs that did not provide this information explained that the Ebola crisis led to a delay in the formulation of their future strategy, which was only recently developed and approved.
Opportunities for improving information about plans for disbursement of DP funds would be facilitated by the WHO Country Cooperation Strategy; and by each DP sending, every year, a decision letter informing Government about its disbursement plans.

## 3.2 Practice 2c: Health Aid is on budget

The Government reported that most DPs directly provide funds to implementing partners and not through the Government. There are areas of Government programmes that are underfunded, including: NCD; mental health, and physical rehabilitation. No programmes of the health sector strategy are overfunded.

The Government mentioned some specific constraints towards achieving a balanced budget: donor dependency; donors channelling aid directly to implementing partners and not to the government. However, they thought that the new MoHS IHPAU provided an opportunity to improve donor confidence and reduce fiduciary risks

Two DPs reported that their funds are recorded on the budget and known by the Government. One reported that their funds are not recorded on the Government budget

Constraints to better inclusion of DPs funds in the national budget included the lack of a multi-year strategy.

The Government, in collaboration with DPs, is developing a 5 year strategy. This is indeed an opportunity for improving information.

# 4 Commitment to establish, use and strengthen country systems

## 4.1 Practice 3: PFM systems are used and strengthened

A project for strengthening the PFM system was implemented until 2013, but its scaling up was hindered by problems related to the indefinite suspension of the private company providing the Integrated Financial Management Information System (IFMIS) Software.

Government reported that most DPs were not using the PFM system for budget execution or financial reporting, nor for auditing procedures. DPs were said to be reluctant to use this system and that they continued to support parallel structures.
DPs, however, explained that the PFM system was not yet well developed, and that it is not customized to their needs, especially as they have their own rules and procedures for financial management. However, they reported to have plans to start using this system through collaboration with the Integrated Health Projects Administration Unit (IHPAU) of the MoHS. IHPAU was established in 2015, with a pool of Consultants for various health sector development areas. The Government however reported that only 5% of planned activities of a joint PFM arrangement for the national sector strategy were implemented.

In the procurement area, the DPs confirmed that they use the government procurement system, and that for auditing purposes, discussions are already underway with Government for them to
start using the services of the Auditor General of Sierra Leone.

All the DPs who participated in the survey reported that their agencies provided sufficient support for HSS, which is one of the focus areas of work, and that further support can be requested during the joint annual appraisal for needy areas identified. However, they explained that support for major projects now goes through IHPAU.

With respect to harmonization of procedures on PFM, DPs report that there are new opportunities with the establishment of the IHPAU. So far only one DP reported that there is harmonization with other DPs, coordinated by IHPAU. A major reason for the lack of harmonization was attributed to internal regulations within the DPs and the MoHS.

## 4.2 Practice 4: Procurement systems are used and strengthened

There is a Government plan for a national procurement & supply system, which allows for global/regional procurement mechanisms. Some DPs are reportedly using this national system. There is, however, the need for strengthening this national system especially as donor support is available for this.

DPs reported that the use of a joint procurement system is rare, since procurement is done through pooled mechanisms or global facilities. Use of the national procurement system by DPs is also rare since DPs have to follow UN rules for procurement, which some DPs say encourage best value for money and fairness; not all DPs are involved directly in procurement process (done by another agency); the national procurement system is on its way to be reformed; currently UNOPS is procuring non health items; but in the future the procurement will be through the national system. Other mechanisms like global regional procurement seem to be preferred.

DPs propose that expanding the SLE One Procurement Team to include other DPs outside the UN could improve harmonization in procurement, and that strengthening alignment of DPs

with national procurement system could be achieved through a unified approach by DPs, and capacity building at government level, and also through the task force that has been set up I for this purpose.

### 4.3 Practice 6: Technical support is coordinated and SSC and TrC supports learning

There is no national TA plan for the country. It is also not clear whether some DPs are supporting Government to develop a national TA plan.

National institutions are not involved in the development of TORs, nor in the selection process of TAs. Only TAs hired by the Government report to it.

Some DPs reported that rules for the recruitment of TAs are public. The need for DPs to hire TAs is discussed with the Government and advertised through the website or, also in the newspapers for national consultants. TORs for the TA are discussed with the country institutions, based on requests from the MoHS. Country institutions are therefore involved in the selection of the TAs. TAs report to the country institutions for which they are recruited, and also to other partners associated with their assignment.

DPs reported that alignment of TA system can be improved by the MoHS establishing a national TA plan and by sharing information on TA

## 5 Commitment to create an enabling environment for CSO and PS to participate in health sector development cooperation

### 5.1 Practice 7: Engagement of CSO

CSO are consulted by the government on the national health sector policies during the development of the plan: e.g. in relation to the community engagement pillar, in workshops and in the implementation of different components of the plan.
CSO participate in the Health Sector Coordinating Committee and sub-committees; feedback mechanisms consist of agenda items and minutes of all meetings circulated to all participants.

Engagement of CSO in health policy processes can be improved through the inclusion, in capacity development programmes, of CSOs representing key affected populations, and also through financial support to enable CSOs at district level to participate in decision making meetings at higher level.

Although the participation of CSOs in planning and monitoring and advocating for policy formulation and other fora is always warmly promoted by Government, a major challenge reported is that CSOs are not consulted in a coherent manner, and that their recommendations are hardly recognised for action. CSOs represented in the FGD proposed that this situation could be improved by engaging CSOs -International as well as National constructively both at national and district or local level.

DPs reported that there are several mechanisms for involving CSOs in programme development and oversight. These include participation in: the Health Development Partners forum, where CSOs are represented; nutrition coordination meetings; the Inter-Agency

Coordination mechanism; the CCM. Through their inclusion in these fora, they participate in discussions and development and implementation of relevant projects.

The extent of inclusion of CSOs in programme activities covered their participation and deployment in post-Ebola programmes. They were also included in nutrition coordination meetings.

The government provides CSOs with financial resources, training, tax free importation, fuel subsidies, and support for identification of hard to reach areas for improving access to health care services. All participants in the FGD agreed that although no direct financial support is given to CSOs by government, they receive duty waiver on their programme related importation. They also benefit from participation in workshops but do not receive any technical assistance from Government.

DPs also reported that CSOs received financial and training support, and other support from them including funds for community mobilization, and TA.

Involvement of CSOs at sub-national level is likely to increase their participation in the promotion of health care. Other areas for support include access to funds for research, advocacy, budget analysis; monitoring of nutritional support and drugs and increased participation in national as well as international meetings.

The Government should provide opportunities for increasing the participation of CSOs through improved coordination of their activities through the MoHS: inclusion of CSOs in the submission process of the health sector budget.

## 5.2 Practice 8: Engagement of PS

The MoHS representative was not familiar with the processes and mechanisms for involving the private sector in health policy processes. Since the focus group discussion could not be held, these notes draw on the interviews with the Government and DPs.

It was reported, however, that he MoHS does not provide the PS with information for facilitating their inputs in the policy process, nor are there feedback mechanisms for this.

Proposals to improve PS inclusion in the health policy issues included: MoHS to prepare a list of PS organisations involved in health and invite them to the health sector committees; engage them in programmes like health insurance schemes (HIS), health sector policies and strategies; PS information to be part of the national HIS and to be included in the M&E framework.

DPs reported that they included the PS in consultations by inviting them to participate in meetings and workshops.

DPs also tried to explain constraints in the poor participation of the PS in health sector programmes as a group: PS not strongly organised; difficult to identify main actors; the lack of interest of the PS and lack of time to build sustainable and efficient relationship with them. Despite these constraints DPs noticed that PS implements some activities through subcontracting by UN Agencies.

Strengthening partnership between DPs and PS could be achieved through improving dialogue and engagement in key activities; lobbying the PS and making them a real active member of the CCM.

## 6 Other observations

The PS did not participate in this Monitoring Process.

## 7 Discussion of findings

A meeting of the Health Development Partners to discuss the findings of the monitoring round, among others, took place at the office of the WHO on Wednesday, March 15, 2017.
The Agenda for that meeting was as follows:

1. Follow-up from last meeting
2. Health Sector Steering Group meeting (14 March)
3. IHP+ 2016 results
4. Resource mapping
5. Human Resources for Health Strategic Plan
6. Transition of 117 (alert line)
7. Princess Christian Maternity Hospital (PCMH) annual review
8. AOB
    a. Sierra Leone Social Health Insurance (SLeSHI)

The following issues were discussed with respect to IHP+ 2016 results:

| Agenda items | Action point(s) |
| --- | --- |
| **3. IHP+ 2016 results**<br><br>- Presentation by Dr. Bailah, COMAHS, on the IHP+ Monitoring of Commitments on Effective Development Cooperation in Health findings for Sierra Leone<br>- The assessment measures 8 effective development cooperation (EDC) practices<br>    o Partners support a single national health strategy<br>    o Health development cooperation is more predictable and health aid is on budget<br>    o Public financial management (PFM) systems are strengthened and used<br>    o Procurement and supply systems are strengthened and used<br>    o Mutual accountability is strengthened<br>    o Technical support is coordinated and south-south cooperation supports learning<br>    o Civil Society Organisations are engaged<br>    o Private sector are engaged<br>- For Sierra Leone, data collected for 2014 from 25% of development partners representing 51% of funding<br>- Yet, there is a lack of data from several partners, and a draft was circulated but no feedback received<br>- A more thorough discussion against each EDC practice, to review performance, identify barriers and agree on actions, was not possible in the HDP meeting, and an electronic follow up was suggested | - Share presentation with HDP *(attached: HDP_15_mar_IHP+)*<br>- HDP to provide feedback via email |

It was agreed that members of the Health Development Partners (HDP) should provide feedback on the IHP+ assessment via email.

The following were the Participants at this HDP meeting:

| No. | Name | Agency/organization | Email |
|---|---|---|---|
| 1. | Tanya Philip | MOHS | tanyatphilip@gmail.com |
| 2. | Robert Marten | WHO | martenr@who.int |
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| 5. | Jing Dong Song | China CDC | sjdccdc@163.com |
| 6. | Hampus Holmer | WHO | hampusholmer@gmail.com |
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| 9. | Anders Nordström | WHO | nordstroma@who.int |
| 10. | Lucy Andrews | DfID | l-andrews@dfid.gov.uk |
| 11. | Amit Bhandari | DfID | a-bhandari@dfid.gov.uk |
| 12. | S. A. S. Kargbo | MOHS, IHP+ designated Focal Point | saskargbo@gmail.com |
| 13. | Nuzhat Rafique | Unicef | nrafique@unicef.org |
| 14. | Samuel Coker | MOHS/DHRH | samuelcoker@gmail.com |
| 15. | Silvestre Ngwa | CHAI/DHRH | ssuh@clintonhealthaccess.org |
| 16. | Dr. Jerry | Chinese Medical Team | 527595203@22.com |
| 17. | Bailah Leigh | COMAHS | bailahleigh@yahoo.co.uk |
| 18. | George Tidwell | HRSA | GTidwell@hrsa.gov |
| 19. | Victor Xie | Chinese Embassy | sl@mofcom.gov.cn |

# 8 Annex 1: list of DPs that were invited and those that participated

| Nr | List of DPs active in the health sector | DPs invited to participate in 5th IHP+ Monitoring Round (please add an X if the DP was invited to participate) | DPs that participated (please add an X if the DP participated) |
|---|---|---|---|
| 1. | AFDB | X | |
| 2. | BMZ | X | |
| 3. | CDC | X | |
| 4. | CHAI | X | |
| 5. | DFID | X | X |
| 6. | EU | X | X |
| 7. | GAVI | X | X |
| 8. | GIZ | X | |
| 9. | KfW | X | |
| 10. | Global Fund | X | X |
| 11. | Irish Aid | X | X |
| 12. | Italy | X | |
| 13. | JICA | X | |
| 14. | OFDA | | |
| 15. | Rescue | X | |
| 16. | Tony Blair African Governance Initiative | X | |
| 17. | UNDP | X | |
| 18. | UNFPA | X | |
| 19. | UNICEF | X | X |
| 20. | USAID | X | |
| 21. | WHO | X | X |
| 22. | WORLD BANK | X | |

** Please add more lines if necessary*

# 9 Annex 2: list of participating CSOs

| Nr | List of CSOs active in the health sector | CSO participated in online survey (please add an X if the CSO participated) | CSO participated in focus group discussion (please add an X if the CSO participated) |
|---|---|---|---|
| 1. | ACF | | |
| 2. | Capanamur | | |
| 3. | Christian Health Association (CHASL) | X | |
| 4. | Concern Worldwide | X | |
| 5. | CRS | | |
| 6. | Doctors with Africa Cuamm | X | |
| 7. | eHealth | X | X |
| 8. | Focus 1000 | X | X |
| 9. | Goal | | |
| 10. | Health Alert | | |
| 11. | Health for All Coalition | | |
| 12. | Health Poverty Action | X | |
| 13. | International Medical Corps | X | |
| 14. | International Rescue Committee | X | |
| 15. | Jericho Road Ministries | X | |
| 16. | King's Sierra Leone Partnership | X | |
| 17. | Marie stopes | | |
| 18. | Medicos del Mundo | X | |
| 19. | MSF Brussels | | X |
| 20. | MSF Switzerland - | | |
| 21. | Partners in Health | | |
| 22. | Save the Children | | |
| 23. | Voluntary Services Overseas (VSO) International | X | |
| 24. | Water, Sanitation and Hygiene Network (WASH-Net) | X | |
| 25. | Welbody Alliance | | |
| 26. | World Vision International | X | |

# 10 Annex 3: list of participating private sector organisations

| Nr | **List of private sector active in the health sector** (as per the definition in the PS tool) | **Private sector organisation participated in focus group discussion** (please add an X if participated) |
|---|---|---|
| **1.** | Activa Pharmacy | |
| **2.** | Aureol Insurance Company | |
| **3.** | Blue Shield Health Management Organisation | |
| **4.** | Citiglobe Pharmacy | |
| **5.** | CM Hospital Freetown | |
| **6.** | ECOMED Lab | |
| **7.** | Emzor Pharma | |
| **8.** | IIC Insurance Company | |
| **9.** | Marz Chem Pharmacy | |
| **10.** | Medical and Dental Council, Sierra Leone | |
| **11.** | Medical and General Insurance Company | |
| **12.** | National Insurance Company | |
| **13.** | Pathology Representative | |
| **14.** | President Private Practitioners –West End Clinic | X |
| **15.** | Psychiatry Representative | |
| **16.** | Radiology Representative | |
| **17.** | Ramsy med Lab | |
| **18.** | Sierra Leone Medical and Dental Association | |
| **19.** | Sierra Leone Nurses and Midwives Association | |
| **20.** | Sierra Leone Pharmacy Board | |
| **21.** | Wes African College of Nurses. | |
| **22.** | Wes African College of Physicians. | |
| **23.** | Wes African College of Surgeons. | |

** Please add more lines if necessary*