WHO COUNTRY COOPERATION STRATEGY

2017-2021

SIERRA LEONE

World Health Organization

REGIONAL OFFICE FOR Africa

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WHO Country Cooperation Strategy, Sierra Leone, 2017–2021

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ABBREVIATIONS

AfDB	African Development Bank
AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
CCA	Common Country Assessment
CCM	Country Cooperation Mechanism
CCS	Country Cooperation Strategy
CHC	community health centre
CRD	chronic respiratory disease
DERC	District Ebola Response Centre
DHIS	District Health Information System
DHMT	District Health Management Team
DHS	Demographic and Health Survey
ECOWAS	Economic Community of West African States
EVD	Ebola virus disease
FHCI	Free Health Care Initiative
GAVI	The Vaccine Alliance
GDP	gross domestic product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GoSL	Government of Sierra Leone
HCW	health care worker
HIS	Health Information System
HRH	Human Resources for Health
IDSR	Integrated Disease Surveillance and Response
IHP+	International Health Partnership
IHR	International Health Regulations
JEE	Joint External Evaluation
JICA	Japan International Cooperation Agency
MCHP	Maternal and Child Health Post
MoHS	Ministry of Health and Sanitation
NHSSP	National Health Sector Strategic Plan

NCDs	noncommunicable diseases
NGO	nongovernmental organization
NPPU	National Pharmaceutical Procurement Unit
ODA	Official Development Assistance
PBF	performance-based financing
PHU	Peripheral Health Unit
PRP	President's Recovery Priorities
RCH	reproductive and child health
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SDGs	Sustainable Development Goals
SLA	Service Level Agreement
SLeSHI	Sierra Leone Social Health Insurance scheme
TBA	traditional birth attendant
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
WASH	Water Sanitation and Hygiene
WB	World Bank
WHO	World Health Organization

PREFACE

The WHO Third Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly to strengthen WHO capacity and make its deliverables more responsive to country needs. It reflects the WHO Twelfth General Programme of Work at country level, and is aimed at enhancing the relevance of WHO's technical cooperation with Member States by focusing on the identification of priorities and efficiency measures for implementing the WHO Programme Budget. It takes into consideration the role of partners, including non-state actors, that support Governments and communities.

The Third Generation CCS draws on lessons from the implementation of the first and second generation CCS, the country focus strategy and the United Nations Sustainable Development Goal Partnership Framework. The CCS is also in line with the global health context and the move towards universal health coverage; integrates the principles of alignment, harmonization and effectiveness, as formulated in the Paris Declaration of 2005 and the Busan Agreement of 2011 on Aid Effectiveness and the principles underlying the "Harmonization for Health in Africa" (HHA) and the "International Health Partnership Plus" (IHP+) initiatives; reflects the policy of decentralization; and enhances the capacity of Governments to improve the outcomes of public health programmes.

The document has been developed in consultation with the key health stakeholders in the country and highlights the expected outcomes of the work of the WHO Secretariat. In line with the renewed country focus strategy, the CCS is to be used to communicate the involvement of WHO in Sierra Leone; formulate the WHO Sierra Leone workplan; advocate, mobilize resources and coordinate with partners; and shape the health dimension of the United Nations Sustainable Development Goal Partnership Framework and other health partnerships in the country.

I commend the efficient and effective leadership role played by the Government in the conduct of this important exercise of developing the CCS. I also request the entire WHO staff under the stewardship of the WHO Representative to facilitate cost-effective implementation of the programmatic orientations of this document for improved health outcomes which contribute to better health and development in Sierra Leone.

Dr Matshidiso Moeti
WHO Regional Director for Africa

EXECUTIVE SUMMARY

The WHO CCS for Sierra Leone presents a medium-term strategic vision for collaboration with the country to support the implementation and development of national health policies, strategies and plans. This is the third CCS for WHO in Sierra Leone after the previous CCS ended in 2013. It intends to strengthen strategic cooperation between WHO and the Government of Sierra Leone after an extraordinary period characterized by the outbreak of Ebola virus disease (EVD) and the subsequent recovery phase.

The country has a number of pressing health challenges, including high rates of maternal and child mortality, a severe communicable disease burden, and a rising incidence of noncommunicable diseases (NCDs). Malaria remains one of the most serious public health issues causing high morbidity and mortality. It is the cause of over 38% of hospital consultations, with 17.6% of those admitted subsequently dying from the disease. Maternal and infant mortality are among the highest in the world, with 1360 maternal deaths per 100 000 live births and an under-five mortality rate of 120 per 1000 live births. Tuberculosis (TB) is another significant public health problem and Sierra Leone is among the 30 countries in the world with the highest TB burden. Meanwhile, the probability of death from any of the four main NCDs (cardiovascular diseases, cancer, diabetes and chronic respiratory disease CRD)) stands at 27.5% among persons between the ages of 30 and 70 years.

The already fragile health system of Sierra Leone suffered a severe shock during the EVD outbreak, with 221 recorded health worker deaths. The severity of the outbreak was exacerbated by limited investment in the country’s health system and a lack of access to affordable health services. The health sector is also largely dependent on external funding sources. Financial assistance is provided by several bilateral and multilateral development partners. The H6 Global Health Partnership – comprising WHO, UNICEF, UNFPA, UNAIDS, UN Women and the World Bank – provides substantial technical support and remains a key partner in developing and delivering health programmes in the area of reproductive and child health. Significant support is also provided by numerous NGOs and academic institutions.

At the same time, Sierra Leone has learnt important lessons and contributes to the international health community through its work on Ebola survivors, the key findings of the Ebola viral persistence study, and the role of community engagement in health-seeking behaviour.

Following a review of the CCS 2008-2013 as well as consultations with the Ministry of Health and Sanitation (MoHS) and partners, the following four strategic priorities have been identified to guide the CCS 2017-2021:

1. improve reproductive, maternal, newborn, child and adolescent health;
2. strengthen capacities for public health security and emergencies;
3. reduce the morbidity and mortality from major communicable and noncommunicable diseases; and
4. support health systems strengthening.

The CCS 2017-2021 is fully consistent with the global and regional context of the Sustainable Development Goals (SDGs) agenda, WHO reform and regional priorities including the implementation of the AFRO Transformation Agenda, and WHO's global core functions. It was developed by a working group comprised of WHO and MoHS staff, and extensively reviewed by key stakeholders including MoHS leadership, directorates and programmes, and UN, civil society and development partners.

The CCS 2017-2021 will be used to guide workplan development over the next five years. A review and monitoring mechanism has been developed to monitor implementation. A mid-term review of the CCS shall be conducted in partnership with stakeholders to assess progress and ensure continued alignment with national priorities.

1. INTRODUCTION

The WHO CCS 2017-2021 outlines the medium-term framework for cooperation with the Government of Sierra Leone (GoSL) through four strategic priorities that will guide the work of WHO in the country, namely to:

1. improve reproductive, maternal, newborn, child and adolescent health;
2. strengthen capacities for public health security and emergencies;
3. reduce the morbidity and mortality from major communicable and noncommunicable diseases; and
4. support health systems strengthening.

This is the third CCS for WHO in Sierra Leone. The first was formulated for the period 2004-2007 and focused on health transition from emergency to recovery and development following 10 years of civil war. It included efforts to rehabilitate the health system, strengthen disease prevention and control, promote health, and support the restoration of essential services in reproductive, child and adolescent health. The second CCS covered the years 2008-2013 and focused on the reduction of communicable and noncommunicable diseases as well as infant, child and maternal morbidity and mortality; strengthening policies and systems to improve access and quality of services, and fostering partnerships and coordination for national health sector development.

The current CCS intends to continue and build strategic cooperation between WHO and GoSL, after the devastating EVD outbreak in Sierra Leone, Guinea and Liberia in 2014/15. The outbreak triggered an organization-wide and global response over 18 months. Priorities were refocused to stop the transmission of the Ebola virus, prevent new outbreaks of the virus, and coordinate the national Ebola response. To revitalize the country following the EVD outbreak, the GoSL launched a 24-month recovery phase through the President's Recovery Priorities in 2015, with three key results areas for the health sector, namely:

(1) saving the lives of 600 women and 5000 children;
(2) preventing, detecting, responding to epidemics and ensuring zero cases of EVD; and
(3) ensuring continuous care for EVD-affected persons and Survivors.

This marked the transition from Ebola to Health as the health sector emerged from a full-blown emergency to a focus on delivering quality health services to the people.

The joint MoHS-WHO 2016-17 workplan reflects these priorities and an MoHS-initiated process to develop the National Health Sector Strategic Plan (NHSSP) 2017-2021 will further inform strategic directions for the coming years. It is expected that the CCS will help with advocacy, programme planning for 2018-19 and 2020-21, and resource mobilization.

2. HEALTH AND DEVELOPMENT SITUATION

2.1 Political, social and macroeconomic context

Demographic profile

Sierra Leone is situated in Western Africa, bordering the North Atlantic Ocean, between Guinea and Liberia. English is the official language of Sierra Leone, which has about 15 ethnic groups. The major tribes include the Mende, Temne, Limba, and Creole. The main religions are Islam and Christianity.[1]

The total population is 7.09 million, with 13% under the age of 5 years and 53% under 20 years.[2] Some 60% of the population is under the age of 25 years; 32% are between the ages of 25-54 years; and 8% are between the ages of 55 years and above. The average life expectancy is 50.1 years (49.3 for men and 50.8 for women).[3] Some 51.4% of the population aged 10 years and above is literate in any language. The literacy rate for males is 59.4% compared to 43.9% for females.[4]

Politics and governance

Administratively, Sierra Leone is divided into four provinces, 14 districts, and 149 chiefdoms. There are three rural provinces, plus an administrative province in the capital city, Freetown. The chiefdoms are hereditary, tribal units of local governance. The two main political parties are the All People's Congress and the Sierra Leone People's Party; numerous other parties exist.

[1] Statistics Sierra Leone, 2013 Demographic and Health Survey
[2] Statistics Sierra Leone, 2015 Population and Housing Census
[3] http://apps.who.int/gho/data/node.cco.ki-SLE
[4] Statistics Sierra Leone, 2015 Population and Housing Census

Sierra Leone is a country emerging from two substantive crises: an eleven-year civil war from 1991 to 2002 and an unprecedented EVD epidemic that lasted from 2014 to 2015, with a minor flare-up in January 2016. Consequently, the country has been considered a 'fragile state'.[5] Nonetheless, Sierra Leone has emerged from these crises, and good progress in governance has enabled the country to work towards the creation of sustainable institutions which can contribute to lasting stability. There has been no major violence in Sierra Leone since the civil war ended. Peaceful parliamentary and presidential elections were held in 2007 and 2012. The next election is due to be held in 2018.

The country's national development plan is the 'Agenda for Prosperity', which defines ambitious development outcomes in nine sectors for the 2013-2018 period. It has an overall objective of reducing poverty, with 19 sub-goals. The Agenda for Prosperity defines the pathway for Sierra Leone to become a middle-income country by 2035. It also identifies many key health-related initiatives that need to be continued or initiated, such as the Free Health Care Initiative (FHCI), the Scaling-Up Nutrition agenda, infrastructure development, anti-corruption interventions, and capacity-building in the public sector. Sierra Leone will hold elections in 2018 and it is anticipated that the next iteration of the country's development plan will be informed by the priorities of the Government after these elections.

Socioeconomic situation

Sierra Leone is rich in natural resources, with its main exports being iron ore, diamonds, rutile, cocoa, coffee and fish. However, poverty levels remain high, with more than 50% of the population living on less than US$ 1.25 a day. The ranking of Sierra Leone in the Human Development Index is 179th out of 188 countries, and the Gender Inequality Index stands at 151.[6]

Buoyed by periods of robust economic growth after the conflict as well as positive aid flows, Sierra Leone has seen gradual improvements in many sectors, as it aspires to achieve middle-income status by 2035.[7] Nevertheless, there are some significant infrastructure and development challenges. Some 70% of the country's youth are unemployed and school completion rates remain low. Only 14% of the country's population has access to electricity (with frequent blackouts) and just 15% have access to financial services.[8]

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[5] African Development Bank, Sierra Leone Country Strategy Paper 2013-2017
[6] Human Development Report 2016
[7] Government of Sierra Leone, Agenda for Prosperity 2013-2018
[8] African Development Bank, Development Effectiveness Review 2015

Table 1: Selected key determinants of health inequities

Indicator	
Gini coefficient	33.99 (2011)
Rural Population (% of total population)	60
Net primary enrolment ratio (boys and girls)	97.9 (2012)
Primary completion rate, total (% of relevant age group)	69.5 (2013)
Literacy rate among adults aged 15 years and above (%)	43 (2007-2012)

Source: World Bank (data.worldbank.org)

Table 2: Sierra Leone's development indicators

Indicator	2005	2014
GDP per capita (US$)	318	538
Poverty ratio (%)	66	53
Tax revenue over GDP (%)	8	11
Access to electricity (%)	9	14
Access to improved sources of water (%)	52	60
Access to improved sanitation (%)	12	13
Road density (%)	-	9

Source: African Development Bank, Development Effectiveness Review 2015

National socioeconomic progress was further affected by the EVD outbreak in 2014, with economic growth contracting to one fifth of its previous level.[9] The real growth rate plummeted to negative figures (-21.5%) in 2015, from 4.6% in 2014 and 20.7% in 2013.[10] Since then, Sierra Leone has refocused on achieving its transformational agenda, including rejuvenating its road building projects, reopening mining companies, and supporting the gradual influx of international businesses.

2.2 Health status

2.2.1 Burden of disease, mortality and nutritional status

Communicable diseases such as malaria, diarrhoea and pneumonia, as well as maternal, neonatal and nutritional diseases still generate the largest share of the disease burden in Sierra Leone (65%), while noncommunicable diseases (29%) and injuries (6%) are increasing in significance. The leading causes of death are currently malaria, lower respiratory infections, cardiovascular diseases, diarrheal diseases and anaemia.[11] Health outcomes are poor across the country, but there are also some important inequities in access to services as well as health outcomes between districts and income levels.[12]

[9] African Development Bank, African Economic Outlook 2016
[10] African Development Bank, African Economic Outlook 2016
[11] Institute for Health Metrics and Evaluation, Global Burden of Disease (http://ghdx.healthdata.org/gbd-results-tool)
[12] http://apps.who.int/gho/data/view.wrapper.HE-VIZ11a?lang=en&menu=hide

Sierra Leone is estimated to have the world's highest maternal mortality ratio, at 1,360 maternal deaths per 100 000 live births in 2015.[13] Such remarkably high maternal mortality has been attributed to multiple factors. The four leading causes of maternal death are bleeding, hypertensive disorders, obstructed labour and sepsis. These can be managed if identified and treated on time, but many patients go to the health facilities at a late stage, when little can be done, or not at all. Health facilities are affected by human resource constraints, lack of training and mentorship, and lack of crucial supplies including drugs and safe blood for transfusions. Furthermore, underlying conditions such as HIV, malnutrition and anaemia; the high proportion of adolescent mothers;[14] and unsafe abortions contribute to the high pregnancy-related mortality.[15]

Child mortality is also very high, with over 120 of every 1000 children dying before the age of five years,[16] mainly from malaria, diarrhoea, pneumonia and malnutrition.[17] Although coverage for many preventive and curative interventions appears to be good, this has not translated into the expected reduction in child mortality, possibly reflecting the challenges in delivering consistent high quality care, supported by an effective laboratory and drug supply system. Furthermore, almost half of all child deaths in Sierra Leone are directly or indirectly attributable to malnutrition, the single greatest cause of child mortality in the country.[18]

Almost one third of under-five children suffered from stunting (significantly decreased growth due to malnutrition) in 2014,[19] while almost one fifth of children in the same age group were overweight or obese in 2013.[20] Anaemia prevalence is 45% among women, 70% in pregnant women, and 75% in under-five children.[21]

2.2.2 Communicable diseases

Communicable diseases are the leading cause of death and disease in Sierra Leone. Of these, malaria is the single biggest killer, accounting for 38% of all hospital admissions, with almost one fifth of admitted patients dying from the disease.[22] Overall, there are over 250 cases of confirmed malaria per 1000 people each year.[23] Pregnant women and children are most vulnerable to the disease, which has a stable incidence all year round with peaks during the rainy season. The climate, poor living conditions and a low uptake

[13] United Nations Maternal Mortality Estimation Inter-Agency Group, Trends in Maternal Mortality: 1990 to 2015
[14] Teenage Pregnancy after Ebola in Sierra Leone: Mapping responses, gaps and ongoing challenges, Secure Livelihoods Research Consortium 2015
[15] Draft RMNCAH strategy 2017-2021
[16] WHO Global Health Observatory
[17] Institute for Health Metrics and Evaluation, Global Burden of Disease (http://ghdx.healthdata.org/gbd-results-tool)
[18] http://www1.wfp.org/countries/sierra-leone
[19] Sierra Leone National Nutrition Survey, 2014
[20] Gebremedhin, S., Prevalence and differentials of overweight and obesity in preschool children in Sub-Saharan Africa, 2015
[21] Sierra Leone Micronutrient Survey, 2013
[22] http://www.afro.who.int/en/sierra-leone/health-topics/4959-malaria.html
[23] http://www.afro.who.int/en/sierra-leone/health-topics/4959-malaria.html

of bed nets – less than half of the population were using bed nets in 2013[24] – contribute to the high malaria burden.

Tuberculosis is another significant public health problem, with an estimated three new infections per 1000 people each year, making Sierra Leone one of the 30 highest-burden countries per capita worldwide.[25] Most patients diagnosed with TB receive treatment, but the key challenge is to diagnose the disease on time. The national HIV prevalence rate is 1.5%. Less than one third of the estimated number of people living with HIV are on antiretroviral therapy.[26] The other major infectious diseases in Sierra Leone are measles, rubella and polio, and large-scale vaccination campaigns are being carried out to curb these preventable diseases. Diarrhoeal diseases are also a major issue, with one in 1000 people dying each year due to lack of safe water and sanitation.[27]

Sierra Leone was severely hit by the most widespread Ebola virus disease (EVD) epidemic in history. EVD is a haemorrhagic viral fever disease. In total, 8706 people were infected, of which 3590 died between May 2014 and March 2016. Active disease surveillance systems have now been put in place to detect and contain any new suspected cases.[28]

2.2.3 NCDs including prevalence of key risk factors

Noncommunicable diseases such as cardiovascular diseases, cancer, diabetes and chronic respiratory disease, as well as injuries, are increasingly responsible for premature death and disability in Sierra Leone, thus contributing to a double burden of communicable and noncommunicable diseases. Poor nutrition and lack of physical exercise contribute to growing obesity rates in the country, with 8% of men and 18% of women being overweight or obese (Body Mass Index over 25) in 2013.[29] This leads to diseases such as diabetes and cardiovascular disease, which are currently among the leading causes of death in the country.[30] Alcohol, tobacco and narcotics including sedatives and marijuana are widely used. Over 40% of men and 10% of women smoke tobacco, these rates being among the highest in the region.[31] Road traffic accidents and other injuries are very common and account for 6% of the overall disease burden. Air and water pollution also contribute to poor health outcomes in Sierra Leone.

[24] Malaria Indicator Survey 2013
[25] WHO Global TB Report 2016
[26] Sierra Leone HIV Epidemiology Report 2016
[27] WHO, Sustainable Development Goals (SDGs), World Health Statistics 2016
[28] http://www.afro.who.int/en/sierra-leone/health-topics/4957-ebola-virus-disease.html
[29] Demographic and Health Survey 2013
[30] Institute for Health Metrics and Evaluation, Global Burden of Disease (http://ghdx.healthdata.org/gbd-results-tool)
[31] http://www.afro.who.int/en/sierra-leone/health-topics/4956-noncommunicable-diseases.html

2.2.4 Risk of epidemics and vulnerability to disasters

Sierra Leone faces risks from several epidemic-prone diseases, including cholera, Ebola virus disease, Lassa fever, monkey pox, meningitis, rabies and yellow fever. Major outbreaks such as cholera in 2012 and Ebola virus disease in 2014/15 have demonstrated the need to strengthen the health system's capacity as required under the International Health Regulations (IHR). Since the Ebola outbreak, major efforts have been made to strengthen the country's preparedness and response capacities. The Public Health National Emergency Operations Centre was established to facilitate technical coordination. At the subnational level, the Ministry established District Emergency Operation Centres to manage events at the district level. The Integrated Disease Surveillance and Response (IDSR) system was revitalized. Rapid response teams have been established and capacitated, and response plans have been updated and tested in simulation exercises.

The MoHS with support from partners carried out a risk profiling exercise to identify potential hazards likely to be experienced by Sierra Leone and their impact. Of 44 identified risks, eight were categorized as Very Low, eight as Low, seven as Moderate, 20 as High, and one as Very High. This exercise also contributed to the Joint External Evaluation (JEE) of IHR capacities undertaken by the country. The JEE report[32] will be used as a basis for the development of a five-year national action plan for health security that will serve as a guide to develop core capacities and capabilities required under the IHR to enhance global health security.

2.2.5 Sustainable Development Goals

Sierra Leone is transitioning to address the Sustainable Development Goals (SDGs) agenda within the broader context of rebuilding institutional capacity after the devastating civil war and Ebola outbreak. The Government of Sierra Leone, with support from partners, is engaged in the 2030 Agenda for Sustainable Development. Agreed upon in 2015, the SDGs provide an opportunity for the country to build on previous gains, while also addressing the recent shocks to the health, social and economic sectors. They are being implemented within the existing framework of the Agenda for Prosperity with targets being adapted to the Sierra Leonean context. Special attention is given to the principle of leaving no one behind, taking marginalized and excluded groups into consideration and ensuring that government agencies are sensitized to collect disaggregated data.

Specifically, as regards SDG 3 on the need to *"ensure healthy lives and promote well-being for all at all ages"*, the Government of Sierra Leone, and in particular the MoHS, has been working actively to develop interventions aimed at achieving the adapted targets. This has entailed ensuring that programmatic and subsector strategies such as the RMNCAH strategy and Human Resources for Health (HRH) strategic plan take into

[32] http://www.who.int/ihr/publications/WHO-WHE-CPI-2017.16/en/

account the required investments and resources to reach SDG 3 targets by 2030. The next NHSSP 2017-2021 will provide the overarching framework for the implementation of SDG 3. Additionally, the determinants of health, which are covered under other SDGs (such as education, water, food security) will have an impact on policies in the health sector and beyond. Considering that under-five mortality and maternal mortality will decrease, it will be even more important to ensure that people not only survive but live long and healthy lives.

The table below presents some of the health-related SDG indicators and their current status in Sierra Leone.

Table 3: Selected health-related Sustainable Development Goals indicators

Goal	Current status
3.1. Reduce maternal mortality ratio to <70/100,000 live births	1,360 maternal deaths per 100,000 live births
3.2. Reduce under-five mortality to ≤25/1,000 live births	120 deaths among under-five children per 1,000 live births
3.3. By 2030, end the epidemics of AIDS, tuberculosis and malaria	0.7 new HIV infections among adults 15-49 years old per 1,000 uninfected people; 310 new TB cases per 100,000 people; 406 new malaria cases per 1,000 people at risk
3.4 By 2030, reduce premature mortality from noncommunicable diseases	27.5% risk of dying from CVD, cancer, diabetes or CRD between age 30 and 70 years
3 c. Substantially increase the health workforce in developing countries	1.9 skilled health workers per 10,000 people

Source: World Health Statistics 2016

2.3 Health system

The Sierra Leonean health system faces severe challenges due to chronic underfunding, a heavy disease burden and vastly insufficient numbers of skilled health workers. Below is a description of the various building blocks of the health system, namely: governance, service delivery, human resources, medical products and technologies, health financing, and health information system.

2.3.1 Governance

The health system is governed by the MoHS at the national level, with District Health Management Teams in each of the 14 districts overseeing primary health care services. In the hospitals, the Medical Superintendent oversees the running of each facility. Sierra Leone has developed and put in place a number of policies and strategies to strategically orient and guide the sector.

The President's Recovery Priorities, launched in mid-2015, focuses on seven priority sectors, including health. Specifically, for the health sector, it seeks to: (1) save the lives of 600 women and 5000 children; (2) prevent, detect, respond to epidemics and ensure zero cases of EVD; and (3) ensure continuous care for EVD-affected persons and survivors. To achieve this, a broader Sierra Leone Health Sector Recovery Plan outlines five main pillars, namely: patient and health worker safety; health workforce development; essential health services; community ownership; and information and surveillance, with a view to building a functional and resilient health system by 2020.

Furthermore, to provide an overarching framework, the MoHS has a National Health Sector Strategic Plan (NHSSP) which provides a broader vision for the health sector. The previous plan was completed during the 2010-2015 period and the MoHS has initiated an inclusive process to develop the next NHSSP 2017-2021, which will be aimed at improving the health and well-being of all Sierra Leoneans. The findings from the review of the previous sector plan as well as salient strategic documents (such as the Health Sector Recovery Plan 2015-2020 and the Basic Package of Essential Health Services 2015-2020) will form the basis for NHSSP 2017-2020. The MoHS is planning a series of consultations with key stakeholders at national, district and community levels to identify goals and targets, main strategic priority interventions, costing and financing and implementation arrangements for the five-year period. The strategic direction is expected to remain the same.

2.3.2 Service delivery

Sierra Leone's health system is divided into three tiers of service delivery: peripheral health units with extended support provided by community health workers; district hospitals; and referral hospitals providing secondary and tertiary patient care. This network of over 1,300 health facilities includes 51 hospitals, of which 24 are operated by the government and the rest owned by private entities as well as nongovernmental and faith-based organizations. The majority of the health services in the country are provided through the public sector.

Hospital services are mainly concentrated in the capital, Freetown, where 20% of the population lives and is served by over 60% of the government-employed health workforce. Overall, over half of the pregnant women have more than four antenatal care visits in one of the health facilities, and a similar proportion give birth in facilities.[33] The most important barrier to accessing health services is the cost of such services, due in part to the high proportion of out-of-pocket spending (see below). Distance to health facility and lack of ambulances or other forms of transport is another important barrier to accessing services, especially in hard-to-reach areas.

The Free Health Care Initiative was introduced in 2010 to abolish user fees for all pregnant and lactating women and under-five children. However, there are still reports of

[33] Draft RMNCAH strategy 2017-21

patients in these categories being charged for services, and there are persistent inequities in reproductive and child health services in level of education, between urban and rural areas, and across the wealth quintiles. In some cases, the referral practices of individual primary health care facilities may lead to inequitable access to hospital care.

Achieving adequate quality of care is a recurrent challenge in Sierra Leone, with low quality giving rise to poor health outcomes even as access to services improves. There have been various initiatives to improve the quality service delivery directly or indirectly through training, monitoring/evaluation and performance-based financing schemes. At present, the MoHS and partners are also focusing increasingly on improving managerial capacity – including planning, budgeting, evaluating and improving service quality – at the district and facility levels as a strategy to facilitate continuous quality improvement.

2.3.3 Human resources

The health system is served by around 20 000 health workers of different cadres (excluding community health workers and traditional birth attendants). Approximately 9000 of these are volunteers: that is, they are not on the government payroll. The MoHS employs over 10 000 health workers across 1323 facilities in the country; of which 70% are health professionals providing patient services and the rest are administrative or support staff.[34]

Capacity, both in terms of numbers and skills, is one of the main barriers to improving the health system. There are roughly four medical doctors per 100 000 inhabitants. Overall, the skilled health professional density is extremely low at 1.9 per 10 000 population – one of the lowest in the world[35] – with 4 doctors, 70 nurses and 5 midwives per 100 000 population.[36] The Ebola outbreak damaged the already weak health workforce in the country as an estimated 257 health care workers contracted EVD.

In a bid to address these challenges, the MoHS has concluded a consultative process to develop a new Human Resources for Health (HRH) Strategic Plan 2017-2021. The Plan is intended to guide investments and activities in planning, developing, deploying and maintaining a resilient health workforce in Sierra Leone, across all tiers of the health sector.

2.3.4 Medical products

Drug availability in health facilities is a major challenge, with regular shortages and stock-outs. Along with human resources, drugs account for most of the spending on the Free Health Care Initiative. Yet, an independent assessment found that in assessed facilities, 6% of the expected stock was missing and 31% of drugs were expired or within

[34] Ministry of Health and Sanitation, Sierra Leone Human Resources for Health Summit, 2016
[35] WHO, Sustainable Development Goals (SDGs), World Health Statistics 2016
[36] Ministry of Health and Sanitation, 2015

six months of expiry,[37] highlighting the need for urgent and sustained improvement in this area.

The legal and policy framework for the pharmaceutical sector has been put in place and disseminated, but is not well-enforced. There are currently varying procurement practices at different levels of the health system, using a mix of push and pull systems. Efforts are underway to establish a National Medical Supply Agency, which will be responsible for strengthening procurement and supply processes.

While there are key challenges, access to essential drugs is improving. In 2016, it was estimated that one third of the people living with HIV were on antiretroviral treatment,[38] and during 2015, essential drugs were available with almost no reported stock-outs for both tuberculosis and malaria.[39]

2.3.5 Health financing

The country is heavily reliant on out-of-pocket payments. In 2013, the total health expenditure was US$ 590 million, or per capita spending of US$ 95 per year, with 62% being out-of-pocket payments. External sources accounted for 24% of the expenditure, with government contributions being only 7%. The remainder of the expenditure came from nongovernmental organizations.[40]

The financing landscape is currently fragmented. The Free Health Care Initiative (FHCI) was introduced in 2010 to abolish user fees for all pregnant and lactating women and under-five children. Ebola Survivors were later added to this initiative. FHCI is mainly funded through external sources and questions about its long-term sustainability persist. In conjunction with FHCI, performance-based financing (PBF), primarily funded through the World Bank Group, was introduced nationwide across all health facilities to improve the quality of and access to basic services. World Bank support to this scheme ended in 2016, with discussions underway to design a new PBF initiative in country.

The National Social Security Insurance Agency under the Ministry of Labour and Social Security has been tasked with establishing the Sierra Leone Social Health Insurance scheme (SLeSHI) and has initiated a series of studies to examine how best to design and implement this scheme in the country, with an expected start date later in 2017.

Overall, there is no clear health financing strategy in Sierra Leone aimed at increasing domestic resources, reducing external dependence and encouraging public-private partnerships. Efforts are underway by MoHS and partners to address these issues and make progress towards universal health coverage.

[37] The Sierra Leone Free Health Care Initiative (FHCI): process and effectiveness review 2016
[38] Sierra Leone HIV Epidemiology Report 2016
[39] Ministry of Health and Sanitation, Health Sector Annual Performance Report 2015
[40] Ministry of Health and Sanitation, Sierra Leone National Health Accounts 2013

2.3.6 Health information system

Building on the information systems established during the Ebola epidemic, including a strengthened Integrated Disease Surveillance and Response (IDSR) system, the country is making progress towards providing better health data for informed decision-making. Routine health information is collected through the District Health Information System 2 (DHIS-2). There are challenges with data quality and incomplete coverage, and a plethora of vertical data systems. Steps are being taken to improve data availability, quality and use, as well as greater integration and interoperability of existing data systems.

A Health Information Systems Strategy is currently being developed by the MoHS to provide strategic direction to the continued efforts in this area. The strategy focuses on building a user-friendly system for collecting, accessing and analysing quality data at all levels of the health system, to inform decision-making and improve service quality. To that end, there is a need for a functioning infrastructure including data systems, as well as clear leadership and reporting structures. To achieve the long-term goal of ensuring that data is used de facto in day-to-day decision-making, leadership and capacity need to be strengthened, as discussed in the Service Delivery section.

2.4 Development partners' environment

2.4.1 Partnership and development cooperation

Sierra Leone is a signatory to the 2005 Paris Declaration on Aid Effectiveness and to the 2008 Accra Agenda for Action. The Government and health partners signed the International Health Partnership (IHP+) Country Compact in 2011 to provide a framework for adherence to the Paris Declaration principles and working arrangements set out in the global IHP+ compact. Following the transformation of IHP+ to UHC 2030, Sierra Leone has remained strongly committed to the principles of effective development cooperation. However, the majority of aid in Sierra Leone is still channelled through project assistance, and a large proportion of this through nongovernmental organizations (NGOs).[41]

Assistance from development partners has consistently been a significant part of health expenditures in Sierra Leone. The official development assistance (ODA) provided to all sectors in Sierra Leone in 2013 was US$ 526 million.

The development cooperation environment changed drastically in 2014/2015 as a result of the global response to the EVD outbreak. Development partners scaled up their financial support and increased their physical presence in the country. During this 2014-

[41] Government of Sierra Leone, Aid Policy

2015 response period, a total of US$ 272 million was disbursed according to the Development Assistance Database Sierra Leone.[42]

Sierra Leone receives financial assistance for the health sector mainly from the United Kingdom, the European Union, Irish Aid, World Bank, African Development Bank (AfDB), The Vaccine Alliance (GAVI), the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), United States Government and JICA.[43]

Technical support from the United Nations system to the health sector is substantial and UN agencies (WHO, UNICEF, UNFPA and UNAIDS) remain key in-country partners in health. AfDB and the World Bank both provide mostly grants while also contributing to analytical work on the economic and social sectors in Sierra Leone.

Furthermore, there are numerous international and local NGOs and academic institutions providing significant support in a wide range of areas to the health sector.

Coordination

The MoHS takes the lead in health sector coordination. The government-led agenda for recovery of all sectors is outlined in the President's Recovery Priorities, and coordinated through its seven priority areas, including health.

Overall, the **Health Sector Coordinating Committee** is the highest consultative and strategic decision-making body in the sector. It is chaired by the Minister of Health and Sanitation and meets on a quarterly basis. The **Health Sector Steering Group** is chaired by the Chief Medical Officer and meets monthly. Various technical working groups and committees guide the work of the sector, including:

a. the Country Coordination Mechanism (CCM), which oversees the implementation of grants financed through the GFATM;
b. the Interagency Coordinating Committee for Reproductive and Child Health; and
c. Technical Working Groups in specific areas of work (e.g., IPC, Lab, Immunization).

In addition, the MoHS aims to strengthen coordination with stakeholders and partners through the introduction of Service Level Agreements (SLA). Every implementing partner in the health sector is required to sign an agreement with the Ministry at the central level, and with the District Management Teams and District Councils. The SLA approach enables the Ministry to document all projects in the health sector and ensure the alignment of proposed projects with national health priorities, adherence to quality standards, and equitable service provision across the 14 districts.

[42] Development Assistance Database Sierra Leone https://dad.synisys.com/dadsierraleone
[43] Development Assistance Database Sierra Leone https://dad.synisys.com/dadsierraleone

Complementary to the government-led coordination structures, health development partners convene regularly, including through a Secretariat of the Health Development Partners Forum which shares information on activities and progress. WHO plays a critical role in supporting partner coordination through this group (secretariat).

The Government is committed to further improvement of the existing coordination structures. To that end, initial recommendations have been developed based on a mapping of structures and functions.

2.4.2 Collaboration with the United Nations system at country level

The United National Development Assistance Framework (UNDAF) 2015-18 is the strategic plan to guide the work of the UN agencies, programmes and funds in Sierra Leone. It is closely aligned with the Agenda for Prosperity (2013-18), which was the overarching national development plan at the time of its formulation. Preparations for the next UNDAF cycle (2019-2022) will start in 2017 and the CCS is expected to inform its health dimension. The post-Ebola recovery priorities, expressed in 13 key results areas, are largely aligned with the Agenda for Prosperity. Two key results areas are Ebola-specific and are consequently not included in the Agenda for Prosperity and UNDAF.

WHO participated in the development of the UNDAF and contributes mainly to the Pillar 3 on Accelerating Human Development. Within this pillar, WHO specifically contributes to outcomes C, D and E.

UNDAF Pillar 3: Accelerating Human Development
Outcome C: Vulnerable populations (women, adolescent girls, children under 5, PLHIV) increase utilization of quality reproductive health services.
Outcome D: By 2018, children under five, adolescent girls, women of reproductive age, vulnerable groups and households are better protected from hunger and show improved nutritional status as a result of stronger UN support to the Government.
Outcome E: By 2018, communities have improved and equitable use of safe drinking water, sanitation and hygiene practices.

Overall, the health dimensions of UNDAF cover one of the priority areas of the GoSL, which is to save the lives of mothers and children. WHO utilizes the experience of the UN family to leverage its convening and coordinating role among partners in health. WHO is one of the six UN agencies that make up the H6 Global Health Partnership which meets to strengthen efforts aimed at improving the survival, health, and well-being of every woman, newborn, child, and adolescent. The other agencies are UNICEF, UNFPA, UNAIDS, UN Women and the World Bank.

Working in partnership and close coordination with partners has proven crucial in supporting Sierra Leone’s health sector, and WHO will continue to be a trusted partner of the MoHS and to contribute to the strengthening of health sector coordination.

Within the UN team, WHO is the lead agency for the interagency preparedness and response work relating to potential public health emergencies (e.g. Ebola, cholera, Yellow fever). This is part of a broader interagency initiative set up under the UN Resident Coordinator for handling both preparedness for and management of emergencies, alongside other events of public health concern.

2.5. Review of WHO's cooperation over the past CCS cycle and experiences from the EVD outbreak

The second CCS (2008-2013) was developed in 2007 in close consultation with the MoHS. The development process included:

- an in-depth review and analysis of key health sector issues, including the factors that influence the health status of the Sierra Leonean population;
- broad consultations and advocacy for the CCS (2008 – 2013) preparation process to ensure that the process was inclusive and participatory; and
- the active involvement of key stakeholders, especially the MoHS and health development partners.

The second CCS had four strategic priorities, namely:

1. Reducing the health, social and economic burden of communicable and noncommunicable diseases: The emphasis was on the prevention and control of malaria, HIV/AIDS, tuberculosis and vaccine-preventable diseases. The strategy also included prevention of communicable diseases and the implementation of IDSR and International Health Regulations (IHR). Additionally, attention was given to the prevention of noncommunicable diseases and the promotion of health and well-being.
2. Reducing infant, child and maternal morbidity and mortality: This included the promotion of responsible and healthy sexual and reproductive health behaviour with special attention to universal access to quality sexual and reproductive health services for adults and adolescents, as well as family planning.
3. Strengthening policies and systems to improve access to health services at all levels.
4. Fostering partnerships and coordination for national health development.

An inclusive and participatory review was conducted in 2013. Some of the main findings were:

- Some 77% of survey respondents consider that WHO has enhanced national ownership of the development, implementation, monitoring and assessment of these national health documents, among others. Most partners acknowledged that WHO: (i) helped the country to lead the development of its NHSP (62%); (ii) supports the implementation of some of the NHSP priorities (62%); and (iii)

supported the country in the development and use of a framework or strategy to monitor and assess NHSP implementation (62%).

- Some of the areas of strength mentioned for WHO included the provision of norms and guidance, close collaboration with MoHS, technical capacity and support for various programmes.
- Among the areas for improvement mentioned is the need to consult partners and stakeholders more on matters of policy and guidance. Furthermore, there is need to share information and provide any feedback from government and implementers on issues affecting the implementation of activities supported by health partners.
- A major constraint identified in the review of the CCS was its limited distribution and utilization both within the WHO country office and among partners, including the MoHS. Some planned activities were not fully implemented due to inadequate funding. In addition, staff members indicated limited knowledge on WHO procedures.
- Coordination and partnerships improved programme implementation.

During 2014-2015, WHO's work mainly focused on supporting the Government to manage and end the EVD outbreak. During 2016, its work gradually transitioned "from Ebola to Health".

- During the Ebola epidemic, many critical lessons were learned on emergency preparedness and response, and substantive efforts have now been made to institutionalize these lessons to a greater extent within the health system.
- Beyond public health security, lessons from the EVD outbreak and 'getting to zero' are currently informing activities in the areas of maternal and child health. In particular, real-time data on maternal deaths has been integrated into the national disease surveillance system, enabling greater visibility, monitoring and response to maternal deaths.
- Meanwhile, strengthened community platforms offer opportunities for promoting effective health-seeking behaviours, and helping to create stronger linkages between communities and their health services.
- More broadly, valuable insights have been gained to strengthen planning and coordination within the health sector. Through all aspects of the recovery process, the year was characterized by a necessary focus on training key personnel, across many different partners and programmes. However, a clear observation from 2016 is that greater efforts must be made to coordinate training and events to avoid overwhelming certain segments of the health system.

The main conclusion for the future is:

- Taking all of the above into consideration, WHO will continue to adapt, learn and share lessons as a core aspect of the technical support it provides within the health sector, while aiming to maximize impact across all of its programmes. This includes work at the national level as well as support to the DHMTs, where teams

aim to consolidate recent progress in management and service delivery. This will be imperative as the country looks to increase resilience at the various tiers of the health system, and to deliver lasting, tangible health gains for the people of Sierra Leone.

3. THE STRATEGIC AGENDA FOR WHO COOPERATION

The strategic priorities of the CCS constitute the medium-term priorities for WHO's cooperation with Sierra Leone. The CCS is informed by the country's health and development needs and challenges, global and regional strategies, and national priorities. The priorities for WHO-Sierra Leone collaboration for 2017–2021 described below are underpinned by an analysis of the current context in Sierra Leone and its likely evolution in coming years.

The Sierra Leone CCS identifies four strategic priorities, namely: (1) reproductive, maternal, newborn, child and adolescent health; (2) public health security and emergencies; (3) communicable and noncommunicable diseases; and (4) health systems strengthening.

Each strategic priority comes with focus areas and strategic approaches for implementation based on the core roles and functions of WHO and the organization's comparative advantages (see further chapter 4).

3.1 Strategic priorities

Strategic Priorities	Focus Areas
Improve reproductive, maternal, newborn, child and adolescent health	Strengthen national and decentralized capacity to improve access to and utilization of quality reproductive, maternal, newborn, child and adolescent health (RMNCAH) interventions
	Support policy dialogue to advance adolescent health programming and improve access to sexual and reproductive health in particular for adolescents
	Strengthen national nutrition surveillance systems, prevention and management of nutrition disorders among mothers, infants and young children, towards the global nutrition targets
	Strengthen immunization systems to provide and sustain universal immunization coverage; undertake acute flaccid paralysis and other vaccine-preventable diseases surveillance; and introduce new vaccines
Strengthen capacities for public health security and emergencies	Support achievement of IHR core capacities, including the nationwide establishment of the Integrated Disease Surveillance and Response system for infectious diseases and other disease threats

	Support the development and implementation of preparedness and response measures for public health risks associated with disasters
	Strengthen national capacities to develop and implement plans and policies to reduce environmental risks to health, including waste management and vector control
Reduce morbidity and mortality from major communicable and noncommunicable diseases	Support the prevention, management and control of HIV and AIDS, malaria, tuberculosis, neglected tropical diseases and other communicable diseases
	Support the prevention and management of noncommunicable diseases and mental health problems
Support health systems strengthening	Strengthen health system capacity and management at the national, district and community levels to deliver and increase access to effective and high quality health services
	Strengthen capacity to develop strategies and interventions to improve the supply and management of human resources for health
	Improve the health information system and ensure integration among the different health information systems
	Provide support for increasing the accessibility, quality and safety of medicines
	Support sustainable health financing

Strategic priority 1: Improve reproductive, maternal, newborn, child and adolescent health

2016 was the first year of implementation of the SDGs and also marked the start of the second phase of the Government's PRP. The PRP prioritizes reduction of maternal and childhood mortality as one of three key results areas, and aims to support the restoration of essential health services such as immunization; reproductive, adolescent and child health; as well as improvements in basic and comprehensive emergency obstetric and neonatal care.

Focus area 1.1 – Strengthen national and decentralized capacity to improve access to and utilization of quality reproductive, maternal, newborn, child and adolescent health (RMNCAH) interventions

1. Support development and implementation of policies, guidelines and protocols;
2. Support the design and implementation of high impact interventions, including those that generate a higher impact among more disadvantaged subpopulations and contribute to the reduction of health inequities;

3. Support the development and implementation of systems, approaches (e.g., training, supervision, mentoring), tools and indicators to measure, deliver and sustain quality RMNCAH services; and
4. Support the institutionalization of Maternal and Perinatal Death Surveillance and Response.

Focus area 1.2 - Support policy dialogue to advance adolescent health programming and improve access to sexual and reproductive health especially for adolescents

1. Support the development of policies, guidelines and protocols to advance programming for adolescent health;
2. Strengthen access to and availability of sexual and reproductive health interventions, especially for adolescents; and
3. Support the development and implementation of the national cervical cancer prevention and control strategy and guidelines.

Focus area 1.3 – Strengthen national nutrition surveillance systems, prevention and management of nutrition disorders among mothers, infants and young children, towards achieving the global nutrition targets

1. Provide support to strengthen the national nutrition surveillance system; and
2. Support the implementation of the Nutrition Action Plan, including through the strengthening of Health in All Policies approaches.

Focus area 1.4 - Strengthen immunization systems to provide and sustain universal immunization coverage; undertake acute flaccid paralysis and other vaccine-preventable diseases surveillance; and introduce new vaccines

1. Provide support to increase immunization coverage nationally, including by adopting equity-oriented approaches to leave no one behind, and reduce the number of unimmunized children;
2. Provide support to develop strategies for the provision of a functioning cold chain;
3. Provide support towards achieving global and regional disease elimination and control targets (polio eradication, measles) through acute flaccid paralysis and other vaccine-preventable diseases surveillance; and
4. Support the introduction of new vaccines.

Strategic priority 2: Strengthen capacities for public health security and emergencies

The PRP include a national commitment to achieve a 'resilient zero' in terms of addressing risks from EVD. Accordingly, the MOHS is working with WHO and partners to enhance capacity at all levels of the health system, in communities, and through intersectoral action to identify, prepare for, prevent and respond to health security hazards and emergencies, especially outbreaks of infectious diseases.

Focus area 2.1 – Support achievement of IHR core capacities, including the nationwide establishment of the IDSR system for infectious diseases and other disease threats

1. Support the implementation of the International Health Regulations and improve cross-sectoral coordination;
2. Provide support to strengthen surveillance, prevention, early detection, rapid response and control of diseases;
3. Provide technical support to strengthen and implement an effective, efficient national disease surveillance and response system;
4. Support the strengthening of infection prevention and control in hospitals and health care facilities; and
5. Support the establishment of laboratory biosafety and biosecurity capacity, improve laboratory diagnostic capacity, and develop an antimicrobial resistance monitoring programme.

Focus area 2.2 – Support the development and implementation of preparedness and response measures for public health risks associated with disasters

1. Support the development and implementation of an Emergency Operations Centre framework; and
2. Support preparedness and response to public health emergencies.

Focus area 2.3 – Strengthen national capacities to develop and implement plans and policies to reduce environmental risks to health, including waste management and vector control

1. Support the development and implementation of policies and guidelines for the reduction of environment-related illnesses.

Strategic priority 3: Reduce morbidity and mortality from major communicable and noncommunicable diseases

The National Steps Survey (2009) indicated that the Sierra Leonean population is likely to be exposed to significant risks from NCDs. The majority (99%) of the population was exposed to at least one of the major risk factors for the onset of NCDs, and 27% were exposed to three to five risks. Hospital-based morbidity data also show a growing trend in cardiovascular diseases, diabetes, cancers and sickle cell disease.

Focus area 3.1 - Support the prevention, management and control of HIV and AIDS, malaria, tuberculosis, neglected tropical diseases and other communicable diseases

1. Support the development and implementation of policies and guidelines for prevention, management and control of HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and other communicable diseases; and
2. Provide technical support in the areas of disease surveillance, antimicrobial resistance and integrated patient-centred care.

Focus area 3.2 - Support prevention and control of noncommunicable diseases and mental health problems

1. Support the development and implementation of health promotion policies and guidelines for the prevention and control of NCDs;
2. Provide technical support for cancer surveillance; and
3. Strengthen national capacities within the MoHS to develop, manage and coordinate delivery of mental health services.

Strategic priority 4: Support health systems strengthening

There is a critical need to strengthen Sierra Leone's health system so as to ensure that people can access the health services they need, when they need them. A strong and well-functioning health system rests on a number of building blocks including: integrated and people-centred service delivery; trained and motivated health workers; well-maintained infrastructure and information systems, and a reliable supply of medicines and technologies, all backed by sustainable financing, strong health plans and evidence-based policies.

Focus area 4.1 - Strengthen health system capacity and management at the national, district and community levels to deliver and increase access to effective and high quality health services

1. Provide technical support to strengthen capacity and management to develop and implement policies and strategies, including the development of the next sector strategic plan along with monitoring and evaluation frameworks to measure progress;
2. Provide technical support to assess and strengthen management capacity at district and hospital levels;
3. Provide technical support to improve coordination of the health sector; and
4. Strengthen District Health Management Teams for the implementation of MoHS priorities, including financial management for programme delivery.

Focus area 4.2 - Strengthen capacity to develop strategies and interventions to improve the supply and management of human resources for health

1. Provide technical support to strengthen the implementation of the 2017 Human Resources for Health (HRH) Policy and HRH Strategic Plan;
2. Support the institutionalization of the Human Resource Information System (HRIS);
3. Provide continued technical guidance on the alignment, harmonization and decentralization of the various HRH information systems; and
4. Provide technical and operational support to the College of Medicine and Allied Health Sciences.

Focus area 4.3 - Improve the health information system and ensure integration among the different health information systems

1. Support implementation of the Health Information System Strategic Plan 2017-2021; and
2. Support the availability and use of routine health information systems (HIS) to inform the development and implementation of policies, at the national and district levels.

Focus area 4.4 - Provide support for increasing the accessibility, quality and safety of medicines

1. Provide technical support to the development and implementation of policies, guidelines and protocols for essential medicines.

Focus area 4.5 – Support sustainable health financing

1. Advocate for and support the development of health financing strategy towards universal health coverage; and
2. Provide technical support to increase internal resource mobilization for sustainable funding of the health sector.

4. IMPLEMENTING THE STRATEGIC AGENDA

Implementation of the strategic agenda will be guided by the core roles and functions of WHO. The main role of WHO is to provide high quality technical advice mainly to the Government of Sierra Leone but also to international and national partners engaged in health.

4.1 Role of WHO in the country

WHO's global core functions and roles are outlined in its 12th General Programme of Work. These are:

(i) providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
(ii) setting norms and standards, and promoting and monitoring their implementation;
(iii) articulating ethical and evidence-based policy options;
(iv) shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
(v) providing technical support, catalysing change, and building sustainable institutional capacity; and
(vi) monitoring the health situation and assessing health trends.

The roles of WHO working in and with Sierra Leone during 2017-2021 will be in line with the above, although some roles will be more prominent than others in the context of Sierra Leone:

Leadership
As lead agency in the area of health, WHO will promote policy dialogue with the Government of Sierra Leone and partners on priority issues in the health sector, including global, regional and national health targets. These include the achievement of health-related SDGs, access to health services and health financing, coordination of a multisectoral response to NCDs, and addressing the social, economic and environmental determinants of health.

WHO will maintain a lead role in health emergencies and work with the Government and partners to strengthen effective institutions and coordination mechanisms to ensure a rapid and well-coordinated response to public health emergencies, fully utilizing the lessons learnt from the Ebola outbreak.

Recognizing the importance of partnerships and coordination for the achievement of better health outcomes, WHO will play a strong role in strengthening coordination at different levels: cross-sectoral coordination between human and animal health, between the various MoHS technical working groups/committees, and between MoHS and development partners.

Norms and standards

WHO plays an important role in setting and providing technical norms, standards and guidelines. The organization will ensure that all stakeholders have access to the latest recommendations, scientific advice and guidelines on all matters critical to health in Sierra Leone. It will continue to support the adaptation of global recommendations to the local context to promote feasibility, sustainability and local acceptance.

Articulating policy options

The role of WHO in providing policy advice is expected to increase relative to previous years. This is a reflection of improved national capacities and the return to normal development processes after the Ebola recovery phase is concluded. WHO will support the Government of Sierra Leone, and the MoHS in particular, in the development of public health guidelines, protocols, plans, strategies and policies. Support will be provided across all strategic priorities and focus areas. Below are examples by strategic priority.

- Under strategic priority 1, WHO will support the development of adolescent health policies and guidelines, the national cervical cancer prevention and control strategy, and strategies for the provision of a functioning cold chain.

- Under strategic priority 2, specific support will include guidelines on antimicrobial resistance monitoring, the emergency operations centre framework, and policies and guidelines for the reduction of environment-related illnesses.

- Under strategic priority 3, WHO will support the development of policies and guidelines for the prevention, management and control of major communicable and noncommunicable diseases, including HIV/AIDS, tuberculosis, malaria and neglected tropical diseases.

- Under strategic priority 4, specific support will include development of the next health sector strategic plan, a health financing strategy, the health information systems strategic plan, and policies and protocols for essential medicines.

Research

In the current CCS cycle, greater emphasis will be laid on analytical work. WHO will support the MoHS in identifying national research priorities and conducting cross-sectoral analyses on the determinants of health. By adapting global best practices, WHO will work with the MoHS in designing high impact interventions to expand access to and

utilization of quality health services. In recent years, Sierra Leone has provided important lessons in the areas of response coordination as well as community sensitization and engagement. WHO will ensure that local best practices are identified and incorporated in strategies and policies.

Technical support
Despite strong national capacity gains in recent years, WHO will continue to play a critical role in providing technical support and strengthening capacities across all strategic priorities and focus areas. It is important to note, however, that there will be a clear move away from capacity substitution to capacity-building for increased sustainability. WHO will gradually phase out of directing interventions at community level through its community engagement programme. Technical support and capacity-building will focus on the national level, and to a lesser extent, on the district level.

WHO's approach to capacity-building will depend on the nature of the task but will usually involve supportive supervision and training, including on-the-job-training and coaching.

Monitoring the health situation and trends
Access to reliable information on the health situation and health trends is essential for all stakeholders in the sector. WHO will work with the MoHS to improve the availability and use of routine health information systems and ensure integration and interoperability among the different information platforms, including the human resource information system, e-integrated disease surveillance, maternal and perinatal death surveillance, nutrition surveillance, antimicrobial resistance surveillance, and cancer surveillance.

WHO will work with all MoHS programmes to establish revised indicator frameworks for their strategies and ensure that there is consistent demand for data and its effective use for programme implementation. Continuous efforts will be made to ensure timely and regular dissemination of information on the health situation and health trends through existing bulletins and the WHO website.

4.2 Presence of WHO in the country

WHO has an office in Freetown, the capital city of Sierra Leone. At the height of the Ebola response in late 2014, WHO also maintained a strong presence in all districts. Under the Ebola response phase, WHO district teams worked to support the District Ebola Response Centres (DERC) in epidemiology, contact tracing, case investigation and rapid response. The responsibilities of the DERCs were later handed back to District Health Management Teams (DHMT) to implement the Government's recovery priorities for the health sector.

The work of the WHO district teams shifted accordingly from Ebola response to capacity-building support for the implementation of the recovery priorities in 2016. At the request of the Government, WHO will maintain a presence in all 14 districts in 2017, albeit with reduced staff embedded in the DHMTs. The focus is on district management strengthening, primary health care and epidemiology.

The WHO country office will be equipped with adequate staff and financial resources to perform the above functions and achieve the strategic objectives of the CCS. WHO anticipates continued down-sizing in overall operations and personnel compared to the Ebola response period. This has already been factored into the staffing plan for 2017 and beyond, and into the budget. While a gradual reduction in staff to match future needs and expectations is anticipated, the WHO country office will maintain a sizeable pool of long-term international advisors as well as national staff to deliver on the CCS. Overall, the staff competencies in the WHO country office are aligned with the CCS strategic priorities.

The strategic agenda will be coordinated through three technical clusters. Managerial, operational and administrative support will be provided by dedicated teams within the WHO country office. The technical clusters are:

(i) Basic Package of Essential Health Services;
(ii) Health Security and Emergencies; and
(iii) Health Systems Strengthening.

The Organization has access to a network of technical experts based in the Intercountry Support Teams, the WHO Regional Office and WHO headquarters, who can be mobilized at the request of the MoHS. Furthermore, the country office will support the cross-cutting organizational priorities related to “leaving no one behind” in the SDGs, including through the application of approaches based on equity, gender, rights and social determinants.

4.3 Using the CCS

The renewed CCS will guide WHO’s work with Sierra Leone from 2017 to 2021, specifically to:

- guide the preparation of the 2018-19 and 2020-21 Programme Budgets and Work Plans;
- guide resource mobilization and advocacy efforts; and
- coordinate the health component of UNDAF and other partnership platforms.

5. MONITORING AND EVALUATION

The CCS will be implemented over three Programme Budget periods. Progress will be monitored on a quarterly basis through detailed reviews of budgets and workplans. These reviews will include the MoHS as a key stakeholder.

CCS implementation will be reviewed at mid-term (2018) by the WHO country office team and the MoHS. The purpose of the mid-term review is to measure progress relative to the focus areas; identify impediments and potential risks that may require changes to the strategic priorities; and identify the actions needed to improve implementation during the second half of the CCS cycle. Furthermore, the mid-tem review will be an opportunity to take into consideration potential new priorities of the new Government after the 2018 elections.

A final evaluation of the CCS is expected to take place in the last year implementation to guide the development of a new strategy. The evaluation will be conducted in partnership with MoHS and health partners to measure the achievements of the CCS strategic agenda, and to identify success factors, impediments, and lessons learnt.

Lessons learnt will be widely shared with stakeholders in Sierra Leone and with other countries.

ANNEXES

Annex 1: Basic Health Indicators

WHO Region	AFRO
World Bank income group	Low-income
CURRENT HEALTH INDICATORS	
Total population in thousands (year)	7,092 (2015)*
% Population under 15 (year)	41% (2015)*
% Population over 60 (year)	5% (2015)*
Life expectancy at birth (year)	50.1 (2015)
Neonatal mortality rate per 1000 live births (year)	34.9 (2015)
Under-five mortality rate per 1000 live births (year)	120.4 (2015)
Maternal mortality ratio per 100 000 live births (year)	1360 (2015)
% DTP3 Immunization coverage among 1-year-olds (year)	86.0% (2015)
% Births attended by skilled health workers (year)	59.7% (2013)
Density of physicians per 1000 population (year)	0.03 (2016)**
Density of nurses and midwives per 1000 population (year)	0.8 (2016)**
Total expenditure on health as % of GDP (year)	11.1 (2014)
General government expenditure on health as % of total government expenditure (year)	17.0 (2014)
Private expenditure on health as % of total expenditure on health (year)	83.0% (2014)
Adult (15+) literacy rate total (year)	43% (2007-2012)
Population using improved drinking water sources (%) (year)	62.6% (2015)
Population using improved sanitation facilities (%) (year)	13.3 (2015)
Poverty headcount ratio at $1.25 a day (PPP) (% of population) (year)	51.7% (2011)
Gender-related Development Index rank out of 148 countries (year)	151 (2015)***
Human Development Index rank out of 188 countries (year)	179 (2015)***

Sources: Global Health Observatory March, 2017, http://apps.who.int/gho/data/node.cco
*2015 Population census, Statistics Sierra Leone
** HRH Country Profile 2017
*** Human Development Report 2016

Annex 2: Validation of CCS Strategic Priorities with relevant frameworks

Strategic Priorities	Focus Areas	NHSSP	WHO GPW	SDGs
Improve reproductive, maternal, newborn, child and adolescent health	Reproductive maternal, newborn, child and adolescent health		3.1 RMNCAH	3.1 Reduce maternal mortality 3.2 End newborn and child preventable deaths
	Sexual and reproductive health		3.1 RMNCAH	5.6 Universal access to sexual and reproductive health
	Nutrition		2.5 Nutrition	2.1 End hunger 2.2 End all forms of malnutrition
	Immunization		1.5 Vaccine-preventable diseases 5.5 Polio	3.2 End newborn and child preventable deaths 3.3 End epidemic of ATM and NTD, combat hepatitis, waterborne diseases
Strengthen capacities for public health security and emergencies	IHR core capacities		5.1 Alert and Response	3.d Strengthen capacity for early warning, risk reduction and management of risks
	Preparedness and response		5.3 Emergency risk and crisis management	1.5 Build resilience of the poor and reduce their exposure and vulnerability
	Health and environment		3.5 Health and environment	3.9 Reduce mortality and illness from hazardous chemicals and air, water and soil pollution and contamination
Reduce morbidity and mortality from major communicable and noncommunicable diseases	AIDS, Tuberculosis, Malaria NTDs		1.1 HIV/AIDS 1.2 TB 1.3 Malaria 1.4 NTDs	3.3 End epidemic of ATM and NTD, combat hepatitis, waterborne diseases and other communicable diseases
	NCDs and mental health		2.1 NCDs	3.4 Reduce NCD mortality, promote mental health and well-being
Support health systems strengthening	Policy and planning		4.1 National health strategies	3.c Increase health financing and enhance health workforce in developing countries
	HRH/Health workforce development		4.2 Integrated service delivery	3.c Increase health financing and enhance health workforce in developing countries
	Health information systems		4.4 Health systems information	3.b Support research and development of vaccines, medicines
	Increase access to Essential Medicines		4.3 Access to medicines	3.c Increase health financing and enhance health workforce in developing countries
	Health financing		4.1 National health strategies	3.c Increase health financing and enhance health workforce in developing countries

Annex 3: Status of progress towards SDG targets

Target	Indicator	Value	Year
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.	Maternal mortality ratio (per 100 000 live births)	1 360	2015
	Proportion of births attended by skilled health personnel (%)	60	2006–2014
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.	Under-five mortality rate (per 1000 live births)	120.4	2015
	Neonatal mortality rate (per 1000 live births)	34.9	2015
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases.	New HIV infections among adults 15-49 years old (per 1000 uninfected population)	0.7	2014
	TB incidence (per 100 000 population)	310	2014
	Malaria incidence (per 1000 population at risk)	406.0	2013
	Infants receiving three doses of hepatitis B vaccine (%)	83	2014
	Reported number of people requiring interventions against NTDs	7 564 272	2014
3.4 By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being.	Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70 (%)	27.5	2012
	Suicide mortality rate (per 100 000 population)	5.6	2012
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.	Total alcohol per capita (> 15 years of age) consumption, in litres of pure alcohol, projected estimates	8.2	2015
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents.	Road traffic mortality rate (per 100 000 population)	27.3	2013
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.	Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)	37.5	2005–2015
	Adolescent birth rate (per 1000 women aged 15-19 years)	125.0	2005–2015
3.8 Achieve universal health coverage, including financial risk protection,	N/A	N/A	N/A

Target	Indicator	Value	Year
access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.			
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.	Mortality rate attributed to household and ambient air pollution (per 100 000 population)	142.3	2012
	Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)	90.4	2012
	Mortality rate from unintentional poisoning (per 100 000 population)	5.7	2012
3.a Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate.	Age-standardized prevalence of tobacco smoking among persons 15 years and older (%, male)	60.0	2015
	Age-standardized prevalence of tobacco smoking among persons 15 years and older (%, female)	12.0	2015
3.b Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.	N/A	N/A	N/A
3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.	Skilled health professionals density (per 10 000 population)	1.9	2005–2013
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.	Average of 13 International Health Regulations core capacity scores	64	2010–2015
2.2 By 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons	Prevalence of stunting in children under 5 (%)	37.9	2005-2015
	Prevalence of wasting in children under 5 (%)	9.4	2005-2015
	Prevalence of overweight in children under 5 (%)	8.9	2005-2015

Target	Indicator	Value	Year
6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all	Proportion of population using improved drinking water sources (%)	63	2015
6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all, and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations	Proportion of population using improved sanitation (%)	13	2015
7.1 By 2030 ensure universal access to affordable, reliable, and modern energy services	Proportion of population with primary reliance on clean fuels (%)	<5	2014
11.6 By 2030, reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality, municipal and other waste management	Annual mean concentrations of fine particulate matter in urban areas (µg/m3)	16.8	2014
13.1 strengthen resilience and adaptive capacity to climate related hazards and natural disasters in all countries	Average death rate due to natural disasters (per 100 000 population)	<0.1	2011-2015
16.1 significantly reduce all forms of violence and related death rates everywhere	Mortality rate due to homicide (per 100 000 population)	13.0	2012
	Estimated direct deaths from major conflicts (per 100 000 population)	0.0	2011-2015

Source: World Health Statistics 2016: Monitoring health for the SDGs, http://www.who.int/gho/publications/world_health_statistics/2016/en/

Annex 4: Sierra Leone JEE scores

Capacities	Indicators	Score	
National legislation, policy, and financing	P.1.1 Legislation, laws, regulations, administrative requirements, policies, or other government instruments in place are sufficient for implementation of IHR	**2**	
	P.1.2 The state can demonstrate that it has adjusted and aligned its domestic legislation, policies, and administrative arrangements to enable compliance with the IHR (2005)	**2**	
IHR coordination, communication, and advocacy	P.2.1 A functional mechanism is established for the coordination and integration of relevant sectors in the implementation of IHR	**2**	
Antimicrobial resistance	P.3.1 Antimicrobial resistance (AMR) detection	**1**	
	P.3.2 Surveillance of infections caused by AMR pathogens	**1**	
	P.3.3 Health-care associated infection (HCAI) prevention and control programs	**2**	
	P.3.4 Antimicrobial stewardship activities	**1**	
Zoonotic disease	P.4.1 Surveillance systems in place for priority zoonotic diseases/pathogens	**1**	
	P.4.2 Veterinary or Animal Health Workforce	**1**	
	P.4.3 Mechanisms for responding to zoonoses and potential zoonoses are established and functional	**1**	
Food safety	P.5.1 Mechanisms are established and functioning for detecting and responding to foodborne disease and food contamination.	**2**	
Biosafety and biosecurity	P.6.1 Whole-of-Government biosafety and biosecurity system is in place for human, animal, and agriculture facilities	**1**	
	P.6.2 Biosafety and biosecurity training and practices	**2**	
Immunization	P.7.1 Vaccine coverage (measles) as part of national program	**3**	
	P.7.2 National vaccine access and delivery	**3**	
National laboratory system	D.1.1 Laboratory testing for detection of priority diseases	**4**	**1**
	D.1.2 Specimen referral and transport system	**3**	**1**
	D.1.3 Effective modern point of care and laboratory based diagnostics	**3**	**1**
	D.1.4 Laboratory Quality System	**2**	**1**
Real-time surveillance	D.2.1 Indicator and event based surveillance systems	**4**	
	D.2.2 Interoperable, interconnected, electronic real-time reporting system	**2**	
	D.2.3 Analysis of surveillance data	**4**	
	D.2.4 Syndromic surveillance systems	**4**	
Reporting	D.3.1 System for efficient reporting to WHO, FAO and OIE	**3**	
	D.3.2 Reporting network and protocols in country	**2**	
Workforce development	D.4.1 Human resources are available to implement IHR core capacity requirements	**2**	
	D.4.2 Field Epidemiology Training Program or other applied epidemiology training program in place	**3**	
	D.4.3 Workforce strategy	**2**	
Preparedness	R.1.1 Multi-hazard National Public Health Emergency Preparedness and Response Plan is developed and implemented	**1**	

	R.1.2 Priority public health risks and resources are mapped and utilized.	1
Emergency response operations	R.2.1 Capacity to Activate Emergency Operations	4
	R.2.2 Emergency Operations Centre Operating Procedures and Plans	3
	R.2.3 Emergency Operations Program	4
	R.2.4 Case management procedures are implemented for IHR relevant hazards.	2
Linking public health and security authorities	R.3.1 Public Health and Security Authorities, (e.g. Law Enforcement, Border Control, Customs) are linked during a suspect or confirmed biological event	4
Medical countermeasures and personnel deployment	R.4.1 System is in place for sending and receiving medical countermeasures during a public health emergency	2
	R.4.2 System is in place for sending and receiving health personnel during a public health emergency	1
Risk communication	R.5.1 Risk communication systems (plans, mechanisms, etc.)	3
	R.5.2 Internal and partner communication and coordination	4
	R.5.3 Public communication	3
	R.5.4 Communication engagement with affected communities	2
	R.5.5 Dynamic listening and rumour management	3
Points of entry (PoE)	PoE.1 Routine capacities are established at PoE.	2
	PoE.2 Effective public health response at points of entry	1
Chemical events	CE.1 Mechanisms are established and functioning for detecting and responding to chemical events or emergencies.	2
	CE.2 Enabling environment is in place for management of chemical Events	2
Radiation emergencies	RE.1 Mechanisms are established and functioning for detecting and responding to radiological and nuclear emergencies	2
	RE.2 Enabling environment is in place for management of Radiation Emergencies	2

Rating Scores:

1. No Capacity: Attributes of a capacity are not in place. (Red)
2. Limited Capacity: Attributes of a capacity are in development stage. Some attributes are achieved and some are undergoing achievement. The implementation has started. (Yellow)
3. Developed Capacity: Attributes of a capacity are in place; however, there is the issue of sustainability and measured by lack of inclusion in the operational plan in National Health Sector Planning (NHSP) and/or secure funding. (Yellow)
4. Demonstrated Capacity: Attributes are in place, sustainable for a few more years and can be measured by the inclusion of attributes or IHR (2005) core capacities in the national health sector plan. (Green)
5. Sustainable Capacity: Attributes are functional, sustainable and the country is supporting other countries in its implementation. This is the highest level of the achievement of implementation of IHR (2005) core capacities. (Green)

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