ReBUILD Consortium

Country Situation Analysis

Sierra Leone

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1 Introduction

This situation analysis is a country-based report that gives a general assessment of the health system of Sierra Leone. It outlines the context of the health system and provides information on issues relating to organisational structure, health financing, regulation and planning, physical and human resources, service delivery and health care reforms.

1.1 Purpose of Country Situation Analysis (CSA)

The CSA provides information on the following:

- Stakeholders in the development of the health system in the country
- Issues relating to poverty, gender and governance
- Gaps in Human Resources for Health (HRH)
- Health financing
- Policy making process and research outputs, gaps and opportunities.

1.2 Background of ReBUILD

For a health system to function effectively, proper financing, even distribution of health professionals and the provision of a stimulating working environment are all factors that contribute to this. Sierra Leone is recovering from a ten year-long civil war and the country is faced with the problems of mal-distribution of health professionals, inappropriate financing of the health system and low incentives for health workers.

In an attempt to address these issues, the ReBUILD consortium, in partnership with stakeholders, will generate robust and quality research based evidence that responds to meet the challenges facing health and related sectors. The consortium plans to engage with

stakeholders from government, academia and civil society throughout the research process to ensure that its work is relevant, available and understood by those who need it.

ReBUILD is a research partnership funded by the UK Department for International Development which began in February 2011. The project is operating in Cambodia, Sierra Leone, Uganda and Zimbabwe to explore how we can strengthen policy and practice related to health financing and health service staffing. In Sierra Leone, research is being led by the College of Medicine and Allied Health Sciences.

2 Methodology

ReBUILD conducted a desk review and key informant interviews to produce and synthesized this to produce a health situational analysis report for the country.

2.1 Desk review

Electronic and hard copies of public health related documents on Sierra Leone's health delivery system were collected. Documents consisted of both published and unpublished annual reports, reviews, survey reports and assessments. These documents were collected from Ministry of Health and Sanitation (MoHS), United Nations Population Fund (UNFPA), Joint United Nations Program on HIV/AIDS (UNAIDS), World Health Organization (WHO), International Fund for Agricultural Development (IFAD), Sierra Leone Association of Non-Governmental Organisations (SLANGO)

Electronic documents were obtained via internet searches using key words that included public health, health regulation, socio-economic context, population, geography and administration, primary health care, post conflict history, stakeholders in the health sector in Sierra Leone and health sector financing.

A total of 384 documents were collected, ranked by relevance and reviewed under the following themes: socio-political context, stakeholders in the development of the health system in the country, health financing, poverty and governance in the country, regulation and planning, policy development, research outputs gaps & opportunities, and human resources for health (HRH).

2.2 Key informant interview

In order to solicit information on the current trend of health issues in the country, the team prepared a list of people to be interviewed. These were officials from the technical, administrative and operational wings of the Ministry of Health and Sanitation (MoHS). Beneficiaries of the health care system were also interviewed.

31 stakeholders from the health sector were interviewed to enable the triangulation of data obtained in the literature reviewed and to obtain additional and complementary information.

2.2.1 Tools used

To conduct the key informant interviews a semi –structured interview guide was used.

2.2.2 Selection criteria of those interviewed

Key informants from the MoHS came from technical, administrative and operational wings of the MoHS. Beneficiaries interviewed during this research were selected based on their knowledge of the health care delivery system before, during and after the war. The responses of the beneficiaries were used to verify the information given by the respondents from the MoHS.

2.2.3 Number and positions of key informants interviewed

31 people were interviewed; 5 from the technical wing; 3 from the administrative wing and 12 from the operational wing of the MoHS. 11 beneficiaries were interviewed.

- Technical wing: 5 respondents (Chief Medical Officer, Head of Research, Director of Planning and Information, Health Economist, Monitoring and Evaluation Specialist).

- Administrative wing: 3 respondents (The Permanent Secretary, Director of Human Resources for Health Manager, Donor NGO Liaison Officer at MoHS).
- Operational wing: 12 respondents (1 Surgeon Specialist, 3 Medical Doctors, The Head of Traditional Medicine, 2 Nursing Sisters, 2 Community Health Officers, 2 SECHN and 1 MCH Aide).
- Beneficiary : 11 respondents (2 inpatient Male Adults, 2 inpatient Female Adults, 2 Pregnant Women, and 5 Lactating Mothers). The selection of the beneficiaries was based on sample of convenience. The four adult inpatient male and female respondents were selected from Connaught Hospital. The two pregnant and five lactation women were selected from Princess Christian Maternity Hospital (PCMH) attending antenatal and postnatal clinics respectively during the period of study.

2.3 Ethical considerations

Visits were made to the officials and beneficiaries selected for interview to brief them about the ReBUILD project and to seek their consent for a short interview to clarify issues raised from the literature review. Information about the purpose and objectives of the study were highlighted during the visits and their participation was voluntary.

2.4 Data synthesis

The information collected was categorised into different topics (the chapters of this documents) with each section explicitly stating any challenges that have been faced.

3 Country background

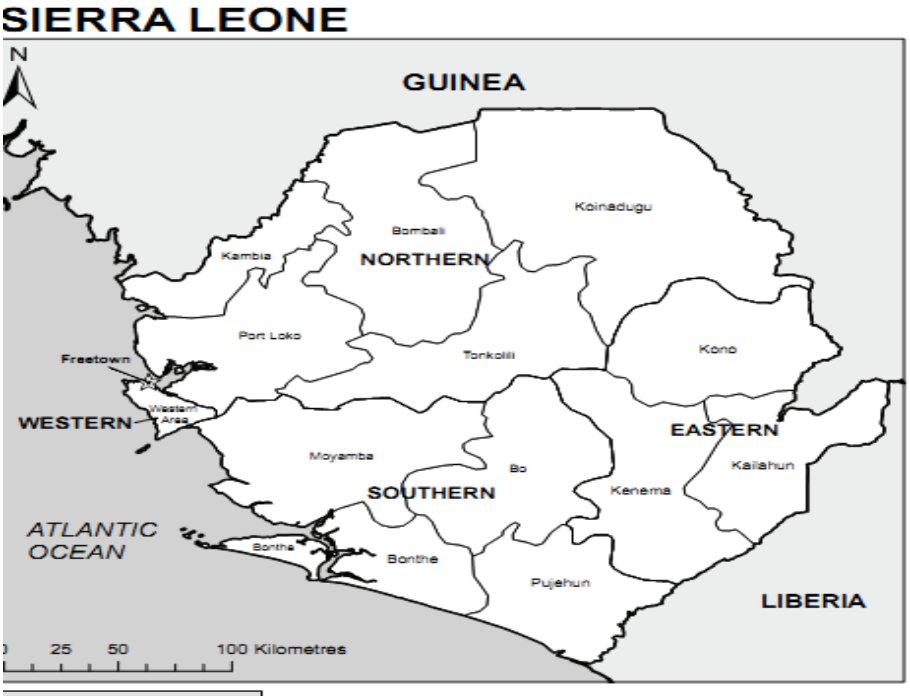
3.1 Geography and administrative structure

Sierra Leone is on the west coast of Africa, bordered by Guinea, Liberia and the Atlantic Ocean. The country has a surface area of 71.740 km^2. It has an annual rainfall of 3150 mm which can sometimes reach 4950 mm a year, making it one of the wettest places in West Africa.

It has an average temperature of 26°C (78.8°F). The climate is tropical with two seasons determining the agricultural cycle: the rainy season from May-October and dry season from November – April which includes *harmattan* (cool, dry winds from the Sahara Desert with a night time temperature as low as 16°C).

The country is divided into 4 regions - West, East, South, and North - and 14 districts, with the capital Freetown located in the western region. The districts are further divided into 149 chiefdoms that are governed by paramount chiefs. As a result of the devolution of services to local communities, the country now has 19 councils which are sub divided into 329 wards. Each ward headed by an elected councilor.

Fig 3.1: Map of Sierra Leone showing its boundaries and administrative division



3.2 Population

The country's population was estimated at 5.7 million in 2009 with a growing rate of 2.3%; one of the highest population growth rates in the world (PRB, 2009). The current population is projected to be 6 million. 37% of the population lives in urban areas while 63% lives in rural areas (SLDHS, 2009). 38% of people in Sierra Leone are under 20 and 17% are under 5.

The total fertility rate remains high at 6.5 with a male to female ratio of 9.4:10 (SLDHS, 2009). The average household size is six.

The country has twenty ethnic groups: Mende, Temne and Creole being the dominant ones. The official language of the country is English but Creole is widely spoken.

Table 3.1: National Demographic Indicators

National Indicators		
Demography & Population	**National Indicators**	**Additional information (e.g. year data refers to)**
Population (number)	5,484,670	2008 projected population
Population under 5 (%)	1,042,544	2011 projected population
Population under Age 15 (%)	41.7%	2004 population census
Population of women of child bearing age	1,307,598	2011 projected population
Urban population	37%	2004 population
Population growth rate	2.3%	SLDHS,2009
Life expectancy-male (years)	47.5 year	Census 2004
Life Expectancy-Female (years)	49.4 years	Census 2004

3.3 Socio-economic context

Sierra Leone is grouped among the least developed countries. It was ranked 178 out of the 187 countries in the Human Development Index (UNHDI, 2008). The country gross domestic product (GDP) growth was constant at 7% per year for the period 2003-2007. The average national income (GNI) per person was US$220 in 2006 and approximately 48% of the population lives on less than $1 a day (UNDP, 2009). The country's main economic sector includes mining, agriculture and fishing. Two-thirds of the working population are engaged in subsistence farming.

The decade-long war, low agricultural productivity, low salaries for formal and informal workers, poor investment, high unemployment rate, corruption, failure to better make use of

natural resources, poor health status and high fertility and population growth rates are the principal causes of poverty (WHO, 2005).

The country has great untapped potential to participate in the world economy: it has underutilised fertile lands on which to cultivate and harvest food; unexploited sea; valuable mineral resources; and it has a large natural deep port with which it could import/export goods.

Sierra Leone's manufacturing sector continues to develop and consists mainly of the raw materials processing and light manufacturing for the domestic market. The service sector has been growing as there have been increasing numbers of Nigerian Banks entering the market.

3.4 Political context and post conflict history

Sierra Leone is a constitutional democracy. The parliament is unicameral and has 124 members (112 elected and 12 Paramount Chiefs who represent the 12 districts in the Northern, Eastern and Southern regions). The country operates multi-party presidential system of government with an Executive President and one parliament. The constitution of the country provides all citizens the right to education and health care without any form of discrimination.

During the civil war, presidential and parliamentary elections took place in 1996. The Sierra Leone People's Party (SLLP) won and Dr. Ahmed Tejan Kabbah was elected as president. The following year, he was removed in a coup d'état but was reinstated with the support of the international military intervention force ECOMOG (Economic Community of West African States Military Observers Group) in 1998. On the 18th of January 2002 President Kabbah declared the war officially over.

On May 14th 2002, the first non-violent presidential and parliamentary elections after the civil war took place and it was declared by both local and international observers to be free and fair.

These elections were won by the SLLP and Kabbah continued as President. During his term of office, the focus was mainly on peace keeping and peace building through strengthening the local army and police forces among other strategies. The Government and justice structures were reinstated.

In May 2004 the first local elections in35 years took place and were won by the SLPP (70%) with 22% of votes for the APC (All People's Congress) and 8% for the remaining parties. The presidential and parliamentary elections of 11th August 2007 were won by the opposition party APC. APC increased its parliamentary seats from 27 to 59, while SLPP decreased from 83 to 43 and the new People's Movement for Democratic Change (PMDC) gained 10 seats. Dr. Ernest Bay Koroma became the new president for Sierra Leone. This was the first time in its history that an opposition party had won an election without a constitutional crisis and/or military intervention. These elections were internationally applauded for their peaceful and generally transparent conduct. The next general election was be held in 2012.

Frustration from the local populations about their exclusion from the profits of diamond mining, the one party system of governance, the high levels of corruption, the centralisation of power, inadequate health delivery services and injustice in the judiciary system were among the principal reasons that resulted in a bloody civil war between March 1991 and November 2002.

In addition to the massive rape of women, the war claimed about 120,000 lives, displaced more than half of the country's population, infringed the rights of thousands of children mobilised as child soldiers, left behind over 7,000 amputees, thousands of war widows and orphans and also decimated more than 3000 villages and towns. Deterioration in the various sectors of governance stimulated the attention of the international community. Various non-governmental organisations (NGOs) presented themselves in Sierra Leone to assist with the relief effort.

The health sector was one of the sectors that severely deteriorated the during the ten year war. Almost all of the health facilities in the peripheral regions were looted or burnt and those that survived were transformed as dwellings for the displaced. The situation was worsened by the exodus of the health workers to other countries for safety and a better life. Health workers also migrated from the rural areas to urban settings and after the war they did not return to their former operational areas. Due to limited resources, government health services were only visible in the district head quarter towns.

During the war, there was an influx of donor funds into the health sector with little or no central coordinating mechanisms to ensure accountability. Moreover, there were no strategies put in place to ensure sustainability of the health services. Although NGOs arrived with health experts, they also recruited health workers from the government service, further depleting public sector human resources for health. Unfortunately, after the war finished these NGOs did not put in place an exit strategy including HRH to sustain health service provision in their operational areas. This created pressure on the government to provide the human and other resources required to deliver the services in these areas.

3.5 Health situation

Malaria is the leading cause of morbidity and mortality amongst children under five. It accounts for 40.3% of the total outpatient visits. Mortality attributed to malaria is 25.4% for all ages and 38.3% for under fives. In the 2009 District Health Survey, it was documented that prior to the study, over 24% of the children under the age of five had malaria in the last two weeks. HIV prevalence is low (1.53%) but nearly half of the people infected (47%) are new infections, implying that there is active transmission going on (SLDHS, 2009). From 2003 to 2006 antenatal HIV prevalence rose from 2.9% to 4.1%.

Sierra Leone has several epidemic prone diseases (e.g. yellow fever, meningitis, cholera, diarrhoea diseases) and in recent years have seen measles, cholera and yellow fever outbreaks.

Table 3.3: Showing key Health Indicators

Key Indicator	SLDHS 2009
Life expectancy at birth, total	42
Life expectancy at birth, male	37.7
Life expectancy at birth, female	42.06
Total mortality rate, total/1,000	20.61
Infant mortality rate	89/1000 live births
Under-five mortality	140/1000 live births
Maternal mortality ratio	857/100,000 live births
Contraceptive prevalence rate (%)	6.7
Health service utilisation rate	0.5 visit per person/year
Underweight prevalence(Children under 5)	21.1/3.5%
Stunting prevalence(children under 5)	36.4%/20.6%
DPT immunisation coverage	54.6%
Fully immunised children	30.2%
Anaemia(children 6- 59 months)	76%
Anaemia(Women15-49)	46%
HIV prevalence (Adults 15-49)	1.5%

Health care costs remain very high Sierra Leone, resulting in poor utilisation (0.5 visits per person per year on average). Poor health indicators could be attributed to these high costs. Out of pocket expenditure of approximately 70% remains among the highest in Africa (NHA Report, 2007). Modest charges tend to exclude over 50% of the population from seeking health care and current exemption systems do not seem to work (Health financing Assessment, Oxford

Policy Management 2008). Practically, in areas where some people cannot afford to pay for health care services, traditional healers whose services are more or less free are the first port of call.

Under the agenda for change (PRSP II), the Government of Sierra Leone introduced the Free Health Care Initiative (FHCI) on 27th April 2010. This was to address Sierra Leone's unacceptably high child and maternal mortality and morbidity by providing free healthcare services for pregnant women, lactating mothers and children under 5.

The first phase of this strategy will see the provision of free quality health care to pregnant women and children under 5 years of age once additional funds are secured to deliver a one-year Emergency Programme of Support.

The second phase aims to provide universal access to free quality health care for all vulnerable groups through the delivery of a 5-year Programme of Work to implement the Health Sector Strategic Plan in its entirety.

3.6 Organisation and governance of the health sector

Sierra Leone's health service delivery is pluralistic. Government, private sector, local and international NGOs and FBOs are all providing health services in the country. There are public, private for profit, private non-profit and traditional medicine practices. Health care is delivered at primary, secondary and tertiary level.

The primary health units (PHUs) are the first line health services and are further sub-classified into three (3) levels: Maternal and Child Health Posts (MCHPs) are situated at villages for population less than five thousand (5,000); Community Health Posts (CHPs) are at small towns

with population between 5,000 and 10,000; Community Health Centres (CHCs) which are located at chiefdom level usually covers population ranging from 10,000 – 20,000.

The Government Hospital Boards Act of 2003 and the Local Government Act of 2004 devolved some government functions to the local councils for effective and efficient service delivery. The local councils now work in collaboration with the District Health Management Team (DHMT) to implement the district health programs. Secondary health care is delivered at district and non-governmental hospitals. Tertiary health care is delivered at regional level and at some non-governmental hospitals.

4 Stakeholders in the development of the health system in Sierra Leone

During the ten year civil war, health care services in rebel controlled areas were mainly delivered through emergency assistance provided by humanitarian organisations. They constructed temporary health facilities and recruited local and international health workers to work in these facilities. These services were provided free of cost. Unfortunately, most of these agencies and had no exit strategy and their departure created a vacuum not only for the beneficiaries but also for the government in taking over their role as service providers.

At the end of the war in 2002, the principal actors were and remain government, United Nations organisations, international and local NGOs, community based organisations (CBOs), faith-based organisations (FBOs), private health institutions, traditional healers, spiritual healers and drug outlets.

4.1 Government

The Ministry of Health and Sanitation (MoHS) is responsible for all health issues in the country. It is divided into three levels: the Minister, two Deputy Ministers of Health & Sanitation, Chief Medical Officer/Permanent Secretary and their deputies at policy level; Directors and their deputies at technical guidance level and; managers, District Medical Officer, Medical Superintendent and the other staff at operational level. The MoHS has multiple leadership responsibilities including policy monitoring and oversight and resource modification.

4.2 United Nations Organisation

UN organisations provide technical support and fund key health activities in the country. Some work through government institutions and other coordinating bodies in the country. The UN

agencies working with health sector are, UNAIDS, UNDP, UNFPA, UN-Women, UNICEF, WHO. Their roles are outlined below:

UNICEF: supports the welfare of mothers and children through the MoHS. UNICEF's major programmes include water, sanitation and hygiene (WASH), Expanded Programme of Immunisation (EPI), maternal and child health, maternal and child nutrition, HIV/AIDS and health policy and advocacy.

World Health Organisation (WHO): Supports the country's priorities of reducing infant and maternal mortality and contributes to the response against malaria, HIV/AIDS. They provide technical assistance to the MoHS for health systems strengthening and nutrition promotion.

International Non-Governmental Organisations (INGOs): These constitute bilateral and multilateral donors. They play a major role in shaping the course of health sector development in Sierra Leone. It was estimated that 11% of health sector funding came from INGOs and UN agencies in 2006 (NHA, 2007). They work closely with the MoHS in supporting and planning health activities. The principal activities of some key INGOs are given below;

DFID: is a UK funding agency. It has a ten year plan to reduce maternal mortality in Sierra Leone. In 2009, DFID's funding was divided between the Government of Sierra Leone and the UN Joint Program, with a small proportion of the health funding going to NGOs. DFID works together with these partners to strengthen the health system and increase access to quality sexual reproductive and child health services. The ReBUILD consortium is a six year research partnership funded by the UK Department for International Development.

African Development Bank (ADB): Is a funding organisation. From 2002 to 2005, the bank funded the construction of PHUs, three district hospitals and rehabilitated the PCM hospital, Connaught hospital and five CHCs in the Western Area. ADB also provided funds for the training

of health staff and the purchase of medical equipment, drugs and vehicles. Between 2006 and 2010 the bank provided funds for the strengthening of MCH programmes in five districts, rehabilitating and re-equipping of 5 maternity wards and 20 PHC facilities, training of PHC workers and the supply of drugs for the health facilities.

World Bank: funds the restoration of essential health services at the primary and secondary level. It funded the construction of one modern referral hospital in Makeni, and the rehabilitation of three existing district hospitals. They are to provide the funds for the construction of four new CHCs and then rehabilitate eight old ones in the country. The bank has provided funds for the construction of an office block and stores for the malaria control programme and environmental health division medical stores at New England and Cline Town.

European Union (EU): is a funding agency**.** Funding ranges from general budget support to total funding of bilateral programs/projects. In recent years EU supported the rehabilitation of sixteen PHUs in four districts and four district hospitals in the country. They also funded three national technical programs (malaria, TB/leprosy and environmental sanitation).

Islamic Development Bank (IDB): Supports the rehabilitation and equipping of hospitals and PHUs throughout the country in the form of loans.

Marie Stopes Sierra Leone (MSSL): is carrying out family planning outreach activities in all 13 districts in Sierra Leone. They have static centres at each district. The Freetown static centre is also an emergency obstetric care centre. In 2009 MSSL started with social franchising for family planning and a pilot voucher scheme.

Activities of other INGOs are given in Annex 3

4.3 Non-Governmental Organisations (NGO)

These are organisations that work in partnership with the MoHS to support programmes and activities in the health sector. There are over fifty NGOs working in health in Sierra Leone. Their activities include but not limited to:

- Community based health activities including health groups (women's groups etc.), sensitisation/information, education, communication (IEC)/behaviour change communication (BCC) etc
- Construction of new PHUs and rehabilitation of old ones
- Supply of drugs, supplies and equipment to PHUs and hospitals
- Promotion and support to health education, nutritional, reproductive and child health, malaria, HIV/AIDS and other programmes of the MoHS
- In-service training of health staff and providing incentives
- Provision of logistics (vehicles, motorbikes) and general support to logistics at all levels.

Medical Research Council (MRC): implements an integrated health program. It is supporting 32 PHUs with a focus on RCH (EmONC, IMNCI), referral systems, rational drug use and reporting community involvement. MRC is also involved in the Public Private Partnership Program, a joint program with Cordaid, KIT and several other SL and Dutch partners to improve maternal health, this includes the smooth running of the new midwifery school in Makeni.

List of some NGOs registered with MoHS in the country is given in annex 3

4.4 Community Based Organisations

Community Based Organisations (CBOs) are group of people coming together with a level of organisation expertise within the community with the aim of taking services to their community of origin. They are formed in a bid to ensure sustainability for certain health programmes

implemented in the districts. Each CBO must be registered with the Ministry of Social Welfare, Gender and Children's Affairs. They range from very small to large groups.

Some health CBOs are funded directly by INGOs or through NGOs to implement some health activities in their communities' e.g. UNICEF funded CBOs providing services for pregnant women and the Global Fund HIV funded CBOs carrying out sensitisation on HIV. Their range of interventions and activities is not clear, nor are the boundaries between them and local NGOs. Most time oversight by the MoHS and the reporting mechanisms back to their communities are not clear. Over three hundred CBOs are said to be carrying out health activities in the country.

4.5 Faith-Based Organisations

Christians and Muslim faith based organisations (FBOs) assisted with health care delivery in Sierra Leone. The Christian FBOs operate under an umbrella association known as the Christian Health Association of Sierra Leone (CHASL). CHASL comprises of seven individual faith denominations each of which operates a mission hospital and/or at least one clinic.

They include United Brethren Church (UBC), United Methodist Church (UMC), Seventh Day Adventist (SDA), Catholic Mission, Wesleyan Church and the Methodist Church of Sierra Leone. The mission hospitals are registered with the MoHS. They are funded by user fees, complemented by external funds from the church and other donors. CHASL coordinates fund raising activities and joint procurement. There is also a duty free concession extended to them when they import drugs and other medical supplies.

The Muslim faith based organisations (e.g. the African Muslim Agency, the Ahmadiyya Muslim Mission and Egypt Hospitals) also operate hospitals and clinics in Freetown and some parts of the provinces.

4.6 Traditional Health Providers in Sierra Leone

There are two main categories of traditional health providers in Sierra Leone; traditional healers and traditional birth attendants (TBAs). Traditional medicine is another means of treatment for certain diseases in communities in the country. Practically, traditional medicines are readily available and affordable to most people in all parts of the country. In some homes, sick family members are treated often with traditional remedies.

Traditional healers: Traditional healers can be generalists, in which they treat all forms of diseases whilst others are specialized in only one form of treatment e.g. bone setters who manipulate broken bones and apply local splints and herbal mixtures. There is a traditional healers association (SLENTHA) established in 1992. There may be over twenty thousand traditional healers country wide.

The Traditional Medicine Act makes provision for the establishment of a Traditional Medicine Practitioners' Board with statutory administrative committees. The Traditional Medicine Practitioners' Board will register and license Traditional Health Practitioners, premises of practice and enforce the code of ethics and standards of practice embodied in the Traditional Medicine Act. The traditional medicine programme run by the MoHS has constructed a training school at Makeni, a healing centre at Kono and has conducted workshops to promote cooperation between traditional medicine practitioners and orthodox doctors. In practice, there is very limited cooperation between traditional healers and other health workers. In some cases each views the other suspiciously as a potential competitor.

Traditional Birth Attendants (TBAs) are usually respected older women who perform deliveries in the rural communities. They are usually leaders of the women's secret society (e.g. wife or family member of the chief). These leaders guide the female coming of age (initiation) process which involves transmission of cultural knowledge and female circumcision.

There are two types of TBAs: trained and un-trained. Currently, the role of TBAs has changed from conducting deliveries to a more general community health worker, that motivates and educates people (e.g. to go to the clinic) instead of doing deliveries. New roles for TBAs are being considered such as social mobilization, or a new cadre of community health worker involved in family planning and immunization promotion. More recently MoHS has redefined the roles of TBAs, clearly stating that TBAs should not do deliveries anymore and that all deliveries should be conducted in health facilities. In an attempt to institutionalise deliveries some districts have by-laws that prohibit community deliveries by TBAs.

Spiritual Healers can be grouped into Christian, Muslim, animist and traditional. They are usually affordable. Healing sessions will last for several days or weeks depending on the nature of the disease.

4.7 Private Sector

Some doctors and nurses work as full-time private practitioners**.** Others who have a formal employment in government or an NGO may do part-time private practice. Private practitioners are found country wide and mostly provide services for the affluent who can meet their costs. Some are organised as large poly-clinics, where the doctors may have some specialist surgical or other skills.

4.8 Drug outlets

Drug peddlers are mobile traders who move from place to place selling pharmaceuticals to people in their communities. Most drug peddlers do not have any formal training in health, although some might have attended community health trainings. In some remote communities, they often embark on activities that are beyond their scope of practice, thereby endangering the lives of the communities they serve. Their services are affordable and available even to the poorest of people in their areas of operation.

4.9 Training institutions contributing to the health sector in the country

To meet the human resource needs in the health sector, government and other NGOs are providing training for the various cadres of health workers in the country. Training is mostly carried out in the following institutions:

- College of Medicine and Allied Health Sciences (COMAHS)
- Njala University, Defense School of Nursing - Freetown
- National Midwifery School Freetown
- Blue Shield School of Nursing - Freetown
- Redeemers School of Nursing-Brookfields, Freetown
- Mattru Jong School of Nursing - Mattru Jong, Bonthe District
- Serabu School of Nursing - Serabu
- Eastern Polytechnic School of Nursing - Kenema
- Nixon Memorial School of Nursing- Segbwema
- Northern Polytechnic –Makeni
- Midwifery School – Makeni
- St. John of God - Lunsar

Detail on the courses offered in the various institutions is given in annex 3

4.10 Regulatory Bodies

Medical and Dental Council of Sierra Leone (MDCSL)

The Sierra Leone Medical and Dental Council (SLMDC) is one of the principal regulatory bodies in the health sector. It was inaugurated on 25th October 1994 by the National Provisional Ruling Council (NPRC) Decree No.12 of 1994 and incorporated into the Laws of Sierra Leone by The Repeal and Modification Act of Parliament in 1996.

The Council registers all medical practitioners and dental surgeons in Sierra Leone. The Council is also empowered by (Amendment) Act No. 1 of 2008, to register, supervise and monitor all hospitals, health centres and private health care facilities in the country. It also has the following responsibilities:

- Registering and disciplining medical practitioners and dental surgeons
- Drawing up a code of ethics for the conduct of medical and dental practice
- Recognition and accreditation of institutions for medical and dental education
- Assessing the competence of housemen prior to permanent registration
- Reprimanding, suspending from practice or removing the names of registered medical practitioners or dental surgeons for professional misconduct or other reasons
- Closing down private health care facilities which are operated without being registered and licensed or do not meet the established standards of Medical or Dental Practices.

Other regulatory bodies in the health sector include the Nursing and Midwifery Board and the Pharmacy Board.

5 Poverty, gender and governance

As a result of high population growth and a decade of civil war that ended in 2002, poverty remains widespread throughout the country. The severe economic decline that went hand in hand with civil war and social unrest destroyed social and physical infrastructure and impoverished the country. In the aftermath of the war poverty has become pervasive and has intensified. Agricultural output has continued to decline, with drastic effects on food prices and rural incomes. The war disrupted education in many areas.

During the conflict, the displacement of the population, the separation of families, violence against women and the breakdown of health services contributed to the spread diseases including HIV/AIDS.

With assistance from international donors, the country is making progress towards securing macroeconomic stability. The country's poorest people are those without land and small-scale farmers, particularly women who head rural households. Poverty is heavily concentrated in rural areas. Approximately 75% of the entire population lived below the poverty line in 2007, and more than half of them lived on less than a dollar a day.

The poorest areas are in the Northern and Southern provinces and in the eastern border of the country, which were particularly hard-hit by the war. With the discovery of iron ore in the north, and operations of African minerals and London Mining companies in these areas, the situation is gradually changing.

Poverty reduction remains a major challenge for the government and the people of Sierra Leone. Approximately 48% of the population lives below the poverty line (UNDP, 2009). Out of pocket expenditure accounted for about 70% of total health expenditure in 2006. However, this may have changed since the introduction of the FHCI in April 2010.

The MoHS in collaboration with its partners are conducting a national health account survey to establish current health expenditure patterns. The major source of funding for the public health sector is through the GoSL budget allocation and partner funding (DFID, EU, ADB, WB, etc). Sustainability is the main challenge as the health sector is heavily funded by partners. This could be partly addressed by developing a health sector financing policy and strategy that is both equitable and pro-poor.

5.1 Gender issues

The country is committed to promoting gender equality, women's empowerment and ending violence against women in a drive towards achieving the human development goals. In Sierra Leone, the Constitution prohibits discrimination against women and provides protection against discrimination on the basis of race and ethnicity.

Before the war, it was evident that women did not have equal access to education, economic opportunities or social freedom. The situation was worse in rural areas; women perform much of the subsistence farming and have little opportunity for formal education.

The current agendas have changed the social landscape. The government and many donors including DFID have made reducing maternal mortality a priority. The FHCI, which was introduced in 2010 favoured pregnant and lactating mothers and has increased women's right to health care services throughout the country. Free education for girls at primary level has also increased their enrolment in schools. Advocacy on female representation at all levels of service delivery by various NGOs is producing positive feedback. Female representation has increased in most sectors compared to five years ago.

5.2 Building good governance at the national and international levels

Good governance is a strategy in the fight against poverty and underdevelopment in Sierra Leone. It is one of the three pillars of the Sierra Leone Poverty Strategy. Wide ranging and

comprehensive governance reform measures are therefore being undertaken. This includes the enactment of the Anti-Corruption Act in 2000; Anti-money Laundering Act in 2004; a new Public Procurement Act 2004; the Local Government Act in 2004; the new Government Budgeting and Accountability Bill; and an Investment Code in 2005.

Institutions have also been set up to improve governance in the country. The Anti-Corruption Commission was set up in 2000 and its capacity to tackle the issue of corrupt practices, especially in public financial management, is being enhanced. A National Anti Corruption Strategy, which outlines the measures needed to reduce the opportunity for corrupt acts to occur, is being implemented.

The Government of Sierra Leone embarked on a decentralization process in 2004. The first local government elections in 32 years were successfully conducted in May 2004 following Paramount Chieftaincy elections in 2003. The elections were aimed at reactivating local government administration at district level, decentralization of central government functions and building local level capacity to manage the decentralised system.

A comprehensive plan for devolving central government functions to the local councils as well as the sequencing of the devolution process has been prepared. A decentralised public financial management system has also been established with the aim of improving public financial management nationally; a special financial management unit has been established in the Ministry of Finance.

5.3 Governance of the health sector

The Government of Sierra Leone is committed, as part of its post-war reconstruction, to the development of a transparent and accountable public sector. The Ministry of Health and Sanitation will ensure that its management structures respond to this requirement. Key elements of this are as follows:

- The Ministry will ensure that it has a clear communications strategy for relaying information to the general public and key stakeholders.
- At all levels of the service there will be opportunities for input by key stakeholders and communities in decision making. At the national level this will occur through both the parliamentary processes and the National Council for Health, Nutrition and Sanitation. At district level hospital and below, this will be ensured through community and professional participation in decision making processes with particular attention to ensuring adequate representation of the voiceless.
- Consultation processes for key decisions in the health sector will be developed. This will ensure that professional bodies including medical, nursing and paramedics, together with key stakeholders such as NGOs, the private health providers and international partners will be consulted on key decisions.
- The Ministry of Health and Sanitation will produce, as part of its planning processes, an annual report on the Health of the Nation.

6 Human resources for health (HRH)

The availability of appropriately trained human resources is an important pre-requisite for the health service delivery in any country. The ten years war devastated the health sector; health workers were killed and those who survived moved out of the country to save their lives. Those who were in the country often went to work for NGOs who offered better conditions of work.

The health workers who stayed in the government service preferred to work in the district head quarter towns. Almost all the health workers that left because of the conflict did not return in peacetime due to the improved terms of service for health workers in other countries. This has had a negative effect on the health system and has caused a major crisis for the government in its response to the heavy disease burden.

Some of the gaps in HRH in Sierra Leone include (but not limited to) the following.

6.1 Number of trained health professionals

In order to effectively implement cost-effective interventions, health workers require the appropriate skills, competencies, training and motivation. Sierra Leone has a high disease burden and the limited human resources available to respond to this. This is having a negative impact on the health system (MoHS Journal 2011). Staff shortage ranges from 40 to 100% in spite of current staffing levels of 6,030 health workers. The total workforce in the public health sector increased by 13.4%, from 7,164 in 2009 to 8,125 in 2010. There is also an inadequate number of specialist health workers.

The density of the health workforce remains very low and is of serious concern. For example, there are 0.4 general medical doctors and 0.5 state registered nurses per 10 000 population. The Health Sector is marred by the paucity of trained and qualified health personnel (MoHS Performance, 2010).

6.2 Maldistribution of health workforce

There is an unfair distribution of health personnel across the districts; with most health workers being concentrated in the Western Area.

Table 6.1 shows the distribution of medical officers and population by district. The ratio of the proportion of total medical officers to the proportion of total population provides a measure of the degree of equality of provision by district. A figure of less than 1 implies a district has fewer medical officers than its population would justify, a figure of more than 2 implies a district has more medical officers than its population merits.

11 of the 13 districts are underprovided for in terms of medical officers. Bonthe and Western Area have twice as many medical officers than is suggested their population needs.

Table. 6.1. Distribution of Health Workers in Sierra Leone

District	Region	% pop, 2011 projection	Medical officers, 2010	% MOs	% MOs/ % pop
Kambia	Northern	7.33	2	3.7	0.51
Koinadugu	Northern	10.36	3	5.6	0.54
Pujehun	Southern	10.30	3	5.6	0.54
Port Loko	Northern	6.84	2	3.7	0.54
Bombali	Northern	8.77	3	5.6	0.63
Moyamba	Southern	5.38	2	3.7	0.69
Kailahun	Eastern	5.32	2	3.7	0.70
Tonkilili	Northern	5.28	2	3.7	0.70
Kenema	Eastern	7.81	3	5.6	0.71
Kono	Eastern	4.34	2	3.7	0.85

Bo	Southern	5.08	3	5.6	1.09
Bonthe	Southern	2.65	3	5.6	2.10
Western	Western	20.63	24	44.4	2.15

There is the absence of some key health personnel in some districts. These staff include: Medical Officers, State Enrolled Community Health Nurses, State Assistant Registered Nurses, Specialist Nurses (Public Health Sister/Officer), Pharmacists, and Laboratory Assistants. Most of the communities are served by a Community Health Officer. Midwives are largely stationed in the Western Area, denying the rest of the country their vital services. As a result, a number of health facilities are served by MCH Aides, who are auxiliary female nurses trained to provide midwifery services at community level.

6.3 Salary uplift for technical health workers

Revenues from user fees were vital to maintain health facilities and pay health workers. In the 2008 Service Delivery and Perception Report, a total of 88% of the respondents cited cost as a major barrier to accessing health services in Sierra Leone. To make the FHCI effective, the government negotiated a substantial increase in pay for all technical health workers starting from March 2010.

The new pay scale incorporates all standard allowances and provides an increase of 200% or more depending on the grade. The pay rise motivates the workers and compensates health personnel for the loss of income from user fees.

6.4 HRH policy not up to date

To date, there has not been any up to date policy on HRH although one has been planned. This plan will map the current situation across the whole health sector and, using trend analysis, will

predict the likely HRH situation over the next 10 years. It will also review current staff cadres in order to identify areas where greater efficiency can be found.

6.5 Lack of accurate assessment of the HRH situation

There is limited accurate assessments of the HRH situation to enhance country capacities to generate, analyse and use data to assess health workforce performance and track progress towards their HRH-related goals.

6.6 No comprehensive plan for implementation of the HRH policy

There is little or no comprehensive plan for the implementation of HRH policy. HRH workers and policy makers in the country do not think through, diagnose, and stimulate dialogue about their HRH challenges by responding to questions and reflecting on the policy implications of their answers.

6.7 Delay in recruitment of staff

Staff training is now more organized due to the HRH Training Policy. However, there is a serious problem with staff recruitment, due to the limited number of training institutions, difficulties with staff retention and brain drain.

In Sierra Leone, there is only one medical university, the College of Medicine and Allied Health Sciences (COMAHS), which is responsible for the training of community-oriented doctors, pharmacists, nurses, laboratory scientists and other health personnel. It was founded in 1988 by the Government of Sierra Leone (GOSL) in cooperation with the Nigerian Government and World Health Organisation (WHO).

Training for medical doctors and nurses is clinically oriented, rather than focused on public health. With respect to nurses, some experts have pointed out that up to two thirds of Africa's disease burden can be addressed by community health nurses. Yet Sierra Leone continues to emphasise the training of professional, degree-level nurses (registered nurses), which takes 3 years and is expensive, rather than the community health nurse (enrolled nurse), which takes 2 years and is less expensive.

6.8 Absence of structured career pathway for most cadres

The Ministry of Health and Sanitation continues to produce essential staff to improve service delivery, there is still no clear career path for specialists, especially those in the provincial areas. There are few performance management mechanisms in place for health workers. However, specialists are promoted on the basis of performance record.

Employees should be promoted according to competence, qualification, experience and performance records. Proper grounding in the management discipline and practice shall precede promotion of medical personnel into management jobs. (HRH-2006).

The hierarchy for doctors is: House Office(HO) ,Medical Officer (MO), Senior Medical Officer (SMO) ,Specialist, Senior Specialist, Consultant, Deputy Chief Medical Officer (DCMO), and Chief Medical Officer(CMO). For nurses it is: Nurse, Staff Nurse, Sister, Senior Sister, Assistant Matron, Matron, Assistant Chief Nursing Officer, and Chief Nursing Officer.

This hierarchy shows that there is a lack of career progression for non-medical public health specialists. This was also confirmed by the minister's speech during the Sierra Leone Medical And Dental Association (SLMDA) mid-year congress in Makeni. The Minister enumerated the inadequate number of trained health professionals, the absence of a structured career pathway for most cadres and the inequitable distribution of available health professionals.

7 Health sector financing

As a result of the devastation to health infrastructure during the ten year war, the government is still struggling to meet the health care demands of the people. Donors and other humanitarian organisations have been supporting the government with the funds and other resources that continues to enable health care delivery in the country.

The expenditure on health as percentage of GDP has increased from 4.3% in 2000 to 7% in 2006. The quality of data has improved with the introduction of National Health Accounts (NHA). Between 2004 and 2006, most sector funds came from household out of pocket (OPP) expenditure, which has been on the rise as a proportion of the total health expenditures (THE): 67.13% in 2004, 64.08% in 2005, and 69.25% in 2006.

Donor funding, as a percentage of Total Health Expenditure (THE) decreased between 2005 and 2006 (from 17.8% to 11%). However, funding from the Government of Sierra Lone grew from approximately 15% of THE in 2004 to 19% in 2006. Funding from parastatals and private employers remained fairly insignificant. The major source of funding for the public health sector has been through budget allocation and this is currently strengthened by heavily indebted poor countries (HIPC) budgetary support from DFID, EU and ADB. The challenge here is to develop a health sector financing policy and strategy that will be both equitable and pro-poor.

In Sierra Leone, no exclusive study has been conducted on health expenditure in the poorest households to assess patterns of catastrophic payments for health care. It is expected that key findings from such a study will be useful in developing a national health financing policy.

7.1 Support from development partners

Support from development partners has been pivotal: disbursement for budgetary support in 2007 was $61.52 million, contributed mainly from the European Union (EU) (US$12.57m), the United Kingdom Department for International Development (DFID) (US$7.77m) and the World Bank (US$10.23m). Development assistance was also received from IFAD, IDB, BADEA, USAID and the Governments of China, Libya, Japan, Iran, Malaysia and Morocco (WHO, 2008).

In general, the long-term economic outlook for the country is good. The International Monetary Fund (IMF) completed a Poverty Reduction Strategy and Growth Facility (PRSGF) in 2005 that helped to stabilise economic growth and reduce inflation. In May 2006, the IMF approved a three year successor arrangement (PRGF2) for Sierra Leone of US$ 46.3 million, in support of the government's 2006-2008 Economic Recovery Program.

Sierra Leone reached the completion point status under the enhanced heavily indebted poor countries (HIPC) initiative in December 2006. The country also qualified for additional debt relief under the Multilateral Debt Relief Initiative (MDRI). An Improved Governance and Accountability Pact (IGAP) aimed at streamlining conditionality for direct budgetary support, has been signed between the government of Sierra Leone (GoSL) and the African Development Bank(ADB), United Kingdom (DFID), European Commission (EU) and the World Bank.

It is expected that significant additional resources will be available for the government's efforts toward attaining the Millennium Development Goals by 2015 (WHO, 2008). The assistance from development partners over the last decade has contributed significantly to health sector expenditure. Financial contributions from the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM) and GAVI alliance, have constituted an important component of the aid flow to Sierra Leone. GFATM funds are channeled through the Government and NGOs, whereas the GAVI fund is channeled through government structures.

Major contributors to development assistance funds for health are shown in Annex 3. Fragmentation of the financial organisational structure of the MoHS could account for the difficulty in accurately stating health expenditure in the country (Price Waterhouse Coopers, 2010).

8 Policy agendas and research outputs

Since the end of the war in 2002, the government has developed a different agenda to meet the health care needs of the population. The current agenda is the Agenda for Change. It reflects the people's belief that the government they elected in a free and fair election will work in partnership with them to improve their social and economic conditions.

In an attempt for the government to actualize this agenda, the second generation of the Poverty Reduction Strategy Paper (PRSP II) covering the period 2008-2012 has been completed. The strategy is based on lessons learnt from implementing PRSP I; a nationwide consultation and priority-setting exercise; and growth diagnostic analysis for Sierra Leone. The focus of the PRSPII is to reduce poverty through economic growth, with an emphasis on the private sector. The strategy was launched in June 2009 and has been submitted to the Boards of the World Bank and the International Monetary Fund (IMF) for consideration.

8.1 The ideal process of policy development and research opportunities

Policy documents which serve to guide implementation are developed through a consultative process. Although not always adhered to, the major steps in health policy development in Sierra Leone are:

- Baseline study; this is conducted to investigate the felt need of the country
- Situational analysis
- Formation of core technical working group
- Formation of policy based CSA by the core working group
- Presentation of the draft policy to a bigger working group
- Internal validation of the document
- Validation of the policy by stake holders

- Draft of cabinet paper by the senior permanent secretary for the submission of the policy document to cabinet
- Policy brief for the minister
- Submission of the policy document to the minister of health
- Approval and adoption of the policy
- Launching of the policy
- Dissemination of the policy
- Implementation of the policy document.

Ideally, for a policy to create a difference it has to be based on evidence and this is only provided by research findings. In Sierra Leone, some of the policies in the health sector are now obsolete and require review to embrace emerging issues. The ReBUIlD consortium will generate research based on evidence and will support and contribute to the review and development of new policies. Some of the policies in the health domain are:

- National Child Health Policy (2007)
- National Cost Recovery Policy (2006)
- National Environmental Health Policy (2000)
- National Food and Nutrition Policy (2003)
- National Health Care Waste Management Programme Policy (2007)
- National Health Education Policy (2000)
- National HIV-AIDS Policy (2002)
- National Human Resource Policy (2006)
- National Malaria Policy (2005)
- National Medicines Policy of Sierra Leone (2004)
- National Policy on Immunisation (2002)
- National Policy on Traditional Medicine (2007)
- Reproductive Health Policy (2007)

- Mental Health Policy (2009)
- Non-Communicable Diseases Policy
- Free health care Policy (2009).

8.2 Research outputs and gaps

8.2.1 Research capacity in Sierra Leone

There are few research institutions in Sierra Leone. In academic institutions, the number of credits given to research at masters level is relatively smaller than that given to research at postgraduate level in other overseas institutions e.g. United Kingdom**.**

Networking between researchers has been poor in Sierra Leone, but has improved since the institution of the HBiomedSL researchers group, which meets bi-monthly and is open to everyone interested in and/or implementing research in Sierra Leone. This group has instituted an annual research conference, which started in March 2009 and was increased to a 2 day conference in March 2010. There was a 3 day research conference in March 2011, with a much wider involvement of not only researchers but also health implementers, policy makers and students. This research conference also included some pre-conference capacity building activities.

Peer review opportunities are limited. Peer review meetings are virtually absent and publication is difficult, especially for authors who are trying to get their first publication and do not have internationally recognised collaborators. The Journal of the Medical and Dental Association (last issue in December 2004) had very limited peer reviewed publications.

The new Sierra Leone Journal of Biomedical Research (SLJBR) has improved this situation. This journal, first published in August 2009, is a peer-reviewed and published at least twice annually. The Journal is available online at www.sljbr.com.

Possible future directions for improvement of research capacity at individual level include:

- Improve capacity of tutors and lecturers to teach and supervise research courses
- Institute special doctoral and masters level training for health research
- Institute regular peer-review meetings, also including students
- Include capacity building, networking and peer-review meetings in each research proposal.

8.2.2 Institutional research in Sierra Leone

There are few institutions undertaking research in health and health related areas in Sierra Leone. Most of these institutions are either donor or NGO driven, with interest limited to needs assessments or a review of their implementation strategies.

The research work undertaken by NGOs and donors are mostly done by consultants, often expatriates with little knowledge about the context of Sierra Leone. Although there is a central coordinating research body that oversees the processes of research at all levels in the country, there is no national health research policy or strategic plan.

This has resulted in duplication, research gaps and wastage of the limited resources that could have been otherwise used wisely. There are limited grants for the management of research at various institutions.

8.3 Government sources of data

The principal sources of data relevant to the analysis of the health system are:

- Population census-last conducted in 2004 and published in 2006. There is no definite information on the date of the next census.

- Demographic and Health Survey (DHS)-last conducted in 2008 and published in 2009.
- Integrated Health Household Survey - last conducted in 2003/4 and published in 2007. Data collection for the next survey was meant to be collected in 2010 but it is still underway (Sept. 2011). It will be probably published in 2013.
- National Health Accounts report 2007.
- 2009 District Health Services Baseline Study-published in 2010.

9 Conclusion and future research agenda

The government continues to play a crucial role in health care delivery throughout the country, even though its allocation to health remains small. Donors such as DFID, WHO, World Bank and UN organisations are supporting the government with funds to carry out health activities. Very little is said about the end users that continue to provide a large proportion of health funds in Sierra Leone.

In the midst of the wide spread poverty, a thorough investigation should be carried out on the coping mechanism of end users, their perceptions on health care delivery and their patterns of spending.

9.1 Health expenditure of the poorest household

The National Health Accounts (2007) noted that 70% out-of pocket payment is spent on health care. However, we do not know what the current expenditure is or what the impact of the FHCI has had on the poorest households.

9.2 Health workers incentives

There has been increase in the salaries of health workers since the inception of the FHCI. However, we do not know whether increases in salaries are sufficient for health workers to relocate to rural/remote areas of Sierra Leone.

9.3 Managing contracts and performance

The government introduced performance-based financing system in conjunction with the District Health Management Teams to provide the resources and incentives to improve coverage and quality of health services.

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Annexes

Annex 2: Questions for the key informant interview under the various research questions.

Stakeholders in the development of the health system in the country

1. Who are the key players in the health sector in the country?
2. How are they positioned?
3. How is health care service delivered in the country?
4. What are the constraints in health care delivery in the country?
5. What should be done to improve health care delivery in the country?

State/identify the issues relating to poverty and governance in the country

1. Can people afford paying for health care at the different levels of health care delivery in the country?
2. Are there strategies/policies in place to protect pro-poor communities in the health care delivery?
3. What are the current government agenda for health?

Identify the gaps in the area of Human Resources for Health (HRH)

1. Is the human resource capacity at the various levels enough to meet the health care demand in the country?
2. What are the conditions necessary to ensure the proper performance of health workers in the country?

Give an indication of how the health sector is been financed

1. How is the Health sector financed in the country?
2. What are the problems associated with the free health care in the country?
3. Are there health financing policies in the country?

4. If yes does it protect the pro-poor community?

Process of policy development, and research out puts gaps & opportunities

1. How are health care policies developed?
2. Are there health research organisations in the country?
3. What are the gaps in the area of health research in the country?

Annex 2: List of some INGOs operating in the health system in Sierra Leone

Irish Aid funds health projects through implementing partners (Concern, Goal, MSF, and Christian Aid), missionary organisations and UN agencies (UNICEF). Funded projects include feeding centres for malnourished children and emergency healthcare for pregnant women, HIV and AIDS.

Japan International Cooperation Agency (JICA) funds and manages two projects in Kambia district; a district health management strengthening project and a water supply management project.

MSF-Belgium is having an integrated primary health care program in Bo and Pujehun. MSF-B is also running a 225 bed-hospital at Gondama that provides emergency secondary care for under-fives, obstetrics and nutrition, including a large 116 bed therapeutic feeding centre and 23 obstetric beds. They are also involved in malaria research.

International Rescue Committee (IRC) runs an EmONC program in Kenema District and a Community Case Management program for under fives in Kono District, which may be expanded to Kenema District with the availability of funds.

Medicos del Mundos (MdM) -works in primary health care and sexual and reproductive health in Koinadugu district.

Save the Children (SC) is involved in the implementation of RCH program in Kailahun, Western Area and Pujehun districts.

CARE International is running a social marketing scheme for condoms and LLITNs in several districts. They are also involved in hygiene promotion, nutrition and RCH programs in 4 districts (Koinadugu, Tonkolili, Bo and Bombali).

International Cooperation Italy (**COOPI)** runs a sexual and reproductive health program in Kono.

Concern Worldwide is active in Tonkolili and Western Area in the area of primary health care program.

Goal is implementing a Water, Sanitation and Hygiene program in Kenema; they are also involved in the social marketing of condom in the Western Area.

Catholic Relief Services (CRS) runs life skills programs in Bo, Freetown and Kenema. They are involved in the WASH programs in Kailahun, Koinadugu and Tonkolili. They are currently sub-recipients of the Global funds for Malaria, TB, HIV and AIDS.

Health Unlimited (HU) works together with Kamakwie hospital in Bombali and surrounding clinics to improve reproductive and child health. In partnership with the Aberdeen West Africa Fistula Centre, they are engaged in fistula prevention project country wide. They are also engaged in health research

Other INGOs working in Sierra Leone include, Christian Aid and Hellen Keller International

List of some NGOs registered with MoHS in the country

- Aberdeen Women's Centre(AWC)
- Afro-Arab kingship Organisation(AAKO)
- Alpha Foundation(AF)
- Cause Canada Sierra Leone Partnership(CCSL)
- Christian Health Association of Sierra Leone(CHASL)
- Cita International-Sierra Leone(CI-SL)
- Community Action for the Welfare of Children(CAWeC)
- Community Action for Psychosocial Services(CAPS)
- Concern Worldwide(CW)
- Egyptian Medical Development Programme(EMDP)
- Faith Healing Development Organisation(FAHDO)
- Faith, Hope, Charity Foundation(FAHOCHA)
- Food, Housing and Agricultural Development Agency(FHADA)
- Fornah Foundation for People with special needs Sierra Leone-Australia(FFSL-A)
- Global Connection Partnership Network(GCPN)
- Greatest Goal Ministries(GGM)
- Hope and New Life Health Care(HNLHC)
- Integrated of Grassroot Organisation for Charity and Development(ICOD)
- Korean Presbyterian Mission(KPM)
- MARIE STOPES(MSSL)
- Medical Research Centre(MRC)
- Methodist Church SL Relief &Development Agency(MCL-RDA)
- National Islamic Development Agency(NIMDA)
- National Organisation for Welbody(NOW)
- Ndegbormei Development Organisation
- Partners for Community Transformation(PACT)

- Partners in Relief and Development(PaRD)
- Planned Parenthood Association of Sierra Leone(PPASL)
- Sierra Leone Health Pride Inc. (SHP)
- Save Humanity Aid Organisation(SAHO)
- Sierra Leone Epilesps Society(SLES)
- Restless Development Partners(RDP)
- The Door Development Agency(TDODEA)
- Voluntary Service Oversea's Sierra Leone(VSOSL)

Information on the courses offered in health training institution in the country:

College of Medicine and Allied Health Sciences (COMAHS) – a college founded in 1988 by the Government of Sierra Leone with a mission to train community-oriented doctors, pharmacists, nurses, laboratory scientists and other health personnel with sound professional and managerial skills suitably qualified to meet international standards and capable to undertake research and pursue further training in specialized areas for health care delivery services.

The faculties and the various disciplines are given below:

Faculty of Basic Medical Sciences

BSc (Hons) Biomedical Sciences

Diploma in Laboratory Sciences

Faculty of Clinical Sciences

Diploma in Community Health

Certificate in Community Health

Bachelor of Medicine and Bachelor of Surgery (MB.Ch.B)

Faculty of Nursing

Diploma in Nursing Education

Diploma in Ophthalmic Nursing

Certificate in Ophthalmic Nursing

BSc (Hons) Nursing

Diploma in Nursing (AKA State Registered Nurse)

Certificate in Nursing (AKA State Enrolled Community Health Nurse)

Faculty of Pharmaceutical Sciences

BSc (Hons) Pharmacy

Diploma in Pharmacy (AKA Pharmacy Technician)

Other institutions training health workers are given below:

Defence School of Nursing

Certificate in Nursing (AKA State Enrolled Community Health Nurse)

National School of Midwifery - Freetown

State Certified Midwife Certificate (SCM)

Blue Shield School of Nursing - Freetown

Certificate in Nursing (AKA State Enrolled Community Health Nurse)

Redeemers School of Nursing, Brookfields - Freetown

Certificate in Nursing (AKA State Enrolled Community Health Nurse)

Njala University (NU)- is another university in the country with a School of Community Health. The school has the following departments:

- Nursing
- Community Studies
- Environmental Health Sciences
- Institute of Health and medical Research.

UNDERGRADUATE PROGRAMMES at NU

1. Bachelor of Science in Public Health
2. Higher Diploma in Community Health
3. Higher Diploma in Pharmacy Dispensing Technology (DPDT)

4. Higher Diploma in Environmental Health
5. Higher Diploma in Medical Laboratory Technology
6. Diploma in Nursing (AKA State Registered Nursing)
7. Diploma in Environmental Health
8. Diploma in Medical Laboratory Technology
9. Diploma in Pharmacy Technicians
10. Certificate in Nursing (AKA State Enrolled Community Health Nursing)
11. Certificate in Community Health
12. Certificate in Environmental Health
13. Certificate in Environmental Health
14. Certificate in Environmental Health
15. Certificate in Environmental Sanitation

POSTGRADUATE PROGRAMME

Master in Public Health

Mattru School of Nursing, Mattru Jong, Bonthe District

State Enrolled Community Health Nurse

Serabu School of Nursing

State Enrolled Community Health Nurse

Eastern Polytechnic School of Nursing, Kenema

State Registered Nurse (Diploma in Nursing)

State Enrolled Community Health Nurse(SECHN)

National Diploma Laboratory Sciences

Nixon Memorial School of Nursing, Segbwema

State Enrolled Community Health Nurse (SECHN)

Northern Polytechnic, Makeni

Certificate in Nursing (KAK State Enrolled Community Health Nurse)

Mental Health Nursing (???)

Midwifery School, Makeni

State Certified Midwife (SCM) Certificate

St. John of God, Lunsar

Certificate in Nursing (KAK State Enrolled Community Health Nurse)

Major contributors to development assistance funds for health and their areas of support are shown in below

Table : showing main Health partners, Areas of support and Aids Flow(US$ in '000) for Health Sector, sierra Leone

Agencies	Area of support	2002	2003	2004	2005	2006	2007
1.Multilateral Agencies							
EU	Rehabilitation, management and capacity building. PHC(HLRRD)	500	750	28,000	1,500	4,619.8	1,733.9
World Bank	Primary and secondary health care, rehabilitation, child survival	15,000	10,000	20,000	7,627.1	8,666.2	
ADB	Pharmaceutical sector, rehabilitation	1,300	1,300	900	2,231.8		
	Health service management			138.3	138.3	138.3	138.3
IDB	Rehabilitation , capacity building			15,000	139.13		
UNICEF	Primary health care, immunisation	25,000	2,700	6,000	6,293.5	7,798.8	
UNFPA	Reproductive health	1,750	2,400	8,000	4,400		

UNDP	Procurement of supplies			15,000			
FAO	Supplementary feeding	2,500	1,500	3,500			
Bilateral agencies							
Ireland	Emergency obstetric				342	720	720
DFID	Health				7,980	8,600.2	