MAKING PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE THROUGH HEALTH FINANCING REFORMS

SIERRA LEONE 2021

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A SUMMARY OF KEY ACTIONS TOWARDS UHC BASED ON THE WHO HEALTH FINANCING PROGRESS MATRIX 2.0

Ministry of Health and Sanitation | April 2021, revised in September 2021

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LIST OF ABBREVIATIONS

CHW	Community Health Worker
DHS	Demographic Health Survey
DHIS	District Health Information System
eIDSR	electronic Infection Disease Surveillance Response
ePETS	Electronic Public Expenditure Tracking Survey
EPI	Expanded Program of Immunization
FHC(I)	Free Health Care (Initiative)
FP	Family Planning
GoSL	Government of Sierra Leone
HF	Health Financing
IPTi	Intermittent Preventive Treatment during Infancy
MoF	Ministry of Finance
MoHS	Ministry of Health and Sanitation
NEMS	National Emergency Medical Services
NGO	Non-Governmental Organization
NHA	National Health Accounts
NMSA	National Medical Supplies Agency
OOP(S)	Out of Pocket Expenditures
PreP	pre-exposure prophylaxis (HIV)
SHI	Social Health Insurance
SLeSHI	Sierra Leone Social Health Insurance
TB	Tuberculosis
UHC	Universal Health Coverage
VHI	Voluntary Health Insurance
WHO	World Health Organization

FOREWORD

The Health Financing Progress Matrix is a tool developed by the WHO Department of Health Systems Governance & Financing. It assesses the country's health financing system against a set of evidence-based benchmarks that were identified as being key in order to make progress towards Universal Health Care (UHC). The matrix signals the direction in which the various aspects of health financing system need to develop.

Sierra Leone has launched the UHC roadmap at the end of 2019, which outlines the next few years of work. In order to setup the health financing system as a solid foundation for progress towards Universal Health Care, the Ministry of Health and Sanitation set out to assess progress so far with the Health Financing Progress Matrix. This made Sierra Leone only the second country in West Africa to finalize this process, and the first to do so without external consultants. The process was fully led and guided by the Principal Health Economist, drawing on a team of health financing experts and enthusiasts within the country. The report was drafted using a consultative approach, and the recommendations were reviewed by several outside experts from both within and outside of the country. This assures a solid evidence-based, while customization to our Sierra Leonean needs is guaranteed.

The findings of the report are clear: there is space to grow. The matrix helped us identify where our biggest growth areas are – in pooling resources and how we purchase services from providers and pay them for it. The MoHS is cognizant that the health financing landscape is a fragmented one, with several pools. The Government remains the biggest pooling agency and aims to build upon that strength and prepare for a Social Health Insurance Scheme. Together with our development partners, we are also looking at how to strengthening provider payment mechanisms, within the current legal framework.

The Health Financing Progress Matrix also showed that we have already done substantive work in Public Financial Management. Our budget information are available online, an annual execution statements are also published. We are in the middle of migrating the internal payment system from paper-based to online, which will further direct us towards Universal Health Care.

The Ministry of Health and Sanitation is thankful to its staff, development partners and other health stakeholders, especially in the health financing space, that contributed to various efforts in shaping this report. The Government of Sierra Leone is fully committed realization of recommendations coming out of this assessment and we look forward to working across the health sector with our partners and stakeholders to ensure every Sierra Leonean will be benefitting from Universal Health Care as soon as possible.

Austin Demby

Dr Austin Demby

Minister of Health and Sanitation

December 2021

METHODOLOGY AND TIMELINE

The WHO has developed a Health Financing Progress Matrix, for countries to assess how far they have come in preparing their health financing systems to achieve UHC. The assessment includes landscaping of existing schemes and 33 questions. The questions are derived from a comprehensive review of research. Each question highlights an issue that research has found to be paramount in order to make progress towards UHC. There is a scoring system attached to it, and recommendations can be made following the assessment.

In Sierra Leone, the Health Financing Progress Matrix (HFPM) assessment was developed by a Technical Working Group (TWG) comprising staff from the Health Financing Unit (HFU) under the Directorate of Policy, Planning and Information (DPPI) at the MOHS and; other INGOs and implementing partners were also included.

The MOHS has embarked on the assessment in January 2021. All technical team members participated in the webinar provided by WHO on the launch of the HFPM. The TWG was headed by the Principal Health Economist (PHE) and supported by health financing experts from agencies and partner organizations, some with public health backgrounds, some with district setting backgrounds, and some with a clinical background. The team had several meetings both via online video conferencing and face to face discussions over a period of two months to assess the situation and document the findings. Discussions were chaired by the Principal Health Economist (PHE) at the MOHS. The report writing took another two months after the discussions and data review. The technical team included:

1. Dr Michael Amara (Principal Health Economist) at the HFU/DPPI/MOHS (Chair)
2. Noemi Schramm (Health Economist)
3. Dr Abdul Jibril N'Jai (Health Financing Specialist)
4. Nathaniel Soloku (Health Economist) at HFU/DPPI/MOHS
5. Yayah Sesay (Economist) at HFU/DPPI/MOHS
6. Celia Demby (Health Financing Technical Assistance)

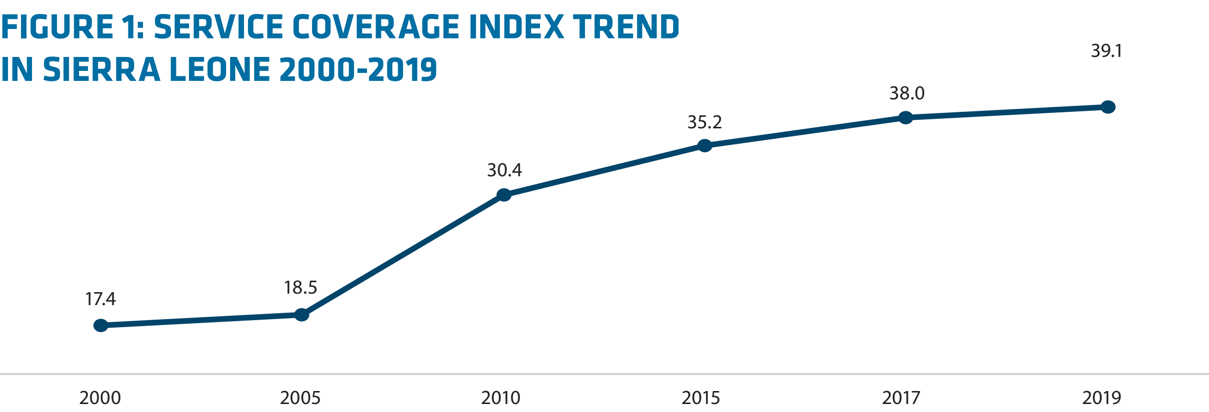
External reviewers subsequently provided feedback. The HFPM was then presented through the PHE to the Health System Cluster Lead, Selassi D'Almeida in the WHO Sierra Leone Country Office, and to Kofi Amponsah at the World Bank Sierra Leone Office.

The plan is next to present to the Minister, MOHS leadership, and the vice president's office as well as other stakeholders.

SIERRA LEONE UHC PERFORMANCE

SDG indicator 3.8.1 relates to the coverage of essential services and is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access (World Health Organization, 2021). The service coverage index is a score between 0 and 100, which in Sierra Leone has doubled since 2000.

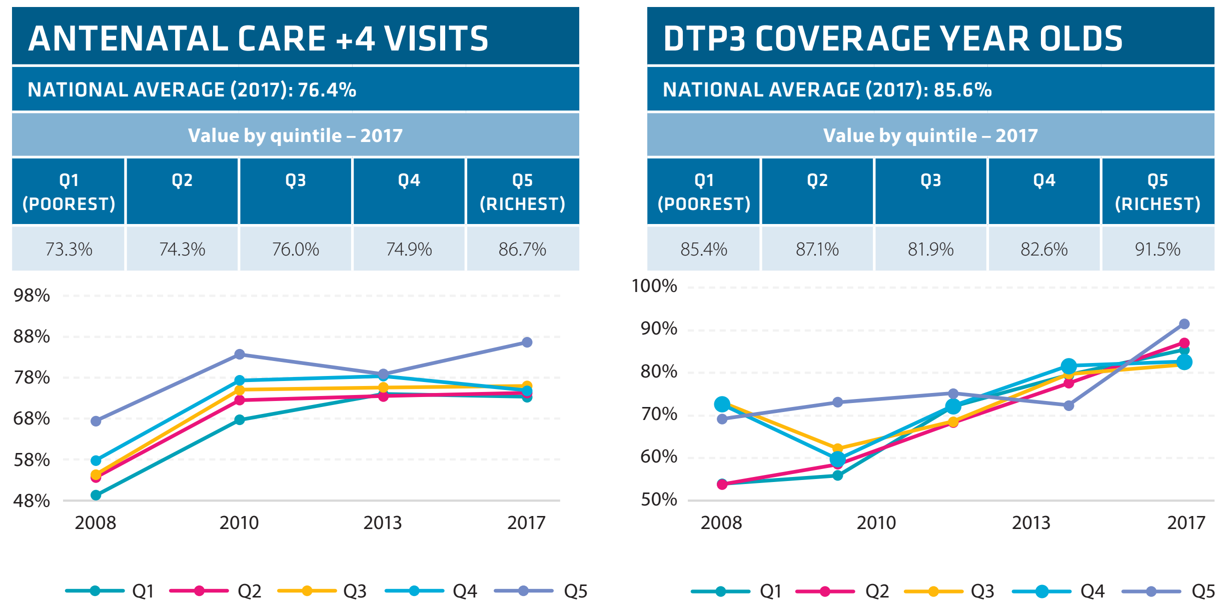
FIGURE 1: SERVICE COVERAGE INDEX TREND IN SIERRA LEONE 2000-2019



Source: Global Health Observatory 2021 (https://www.who.int/data/gho/data/themes/topics/service-coverage)

For some service components of the index, it is possible to obtain disaggregated information, as shown in Figure 2, to get a picture of inequalities in access, which have decreased over time.

FIGURE 2: ANTENATAL CARE AND DTP3 COVERAGE BY QUINTILE IN 2017



ANTENATAL CARE +4 VISITS

NATIONAL AVERAGE (2017): 76.4%

Value by quintile – 2017				
Q1 (POOREST)	Q2	Q3	Q4	Q5 (RICHEST)
73.3%	74.3%	76.0%	74.9%	86.7%

DTP3 COVERAGE YEAR OLDS

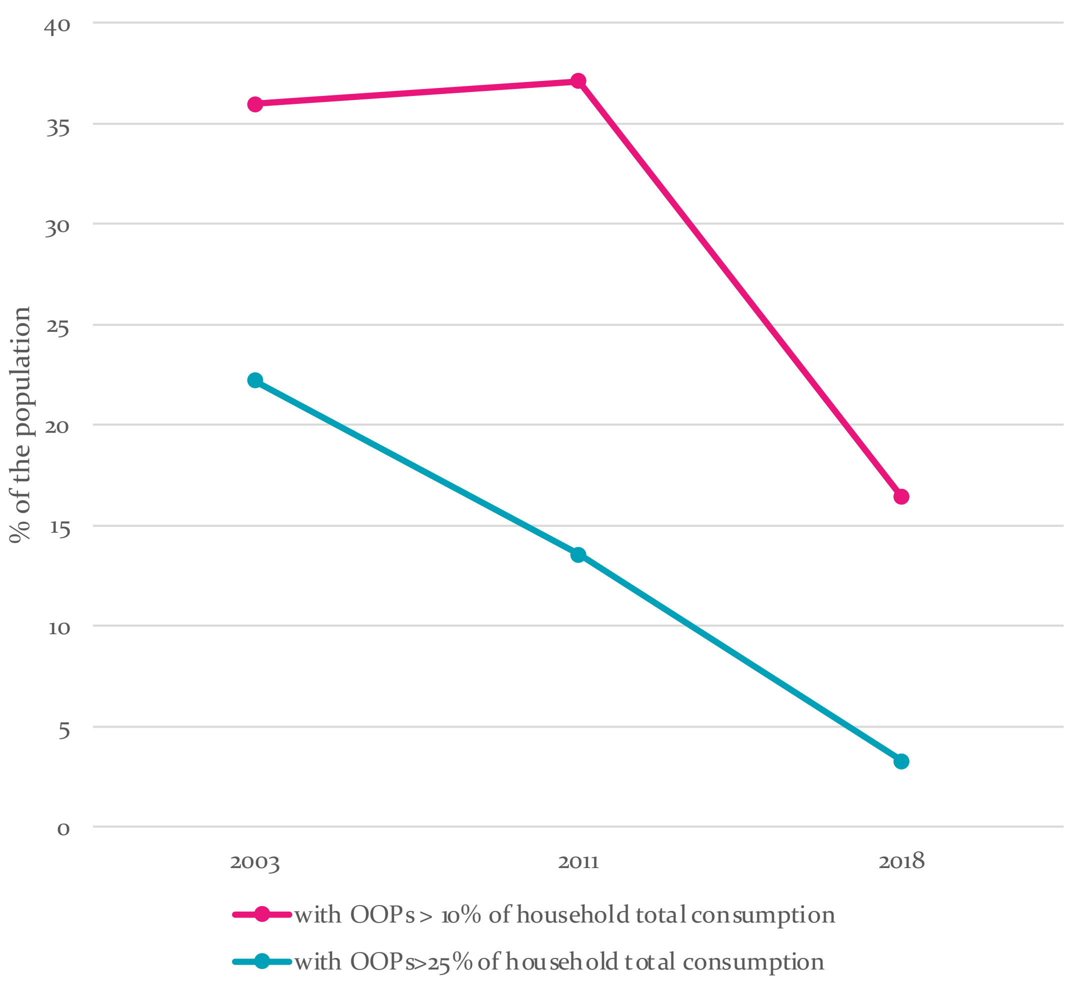
NATIONAL AVERAGE (2017): 85.6%

Value by quintile – 2017				
Q1 (POOREST)	Q2	Q3	Q4	Q5 (RICHEST)
85.4%	87.1%	81.9%	82.6%	91.5%

Source: https://apps.who.int/gho/data/node.imr

SDG indicator 3.8.2 relates to financial protection, measured in terms of catastrophic spending and defined as the "Proportion of the population with large household expenditure on health as a share of total household expenditure or income". Large is defined using two thresholds first greater than 10% of the household budget and secondly greater than 25% of the household budget. The incidence of catastrophic spending has reduced substantially since 2003.

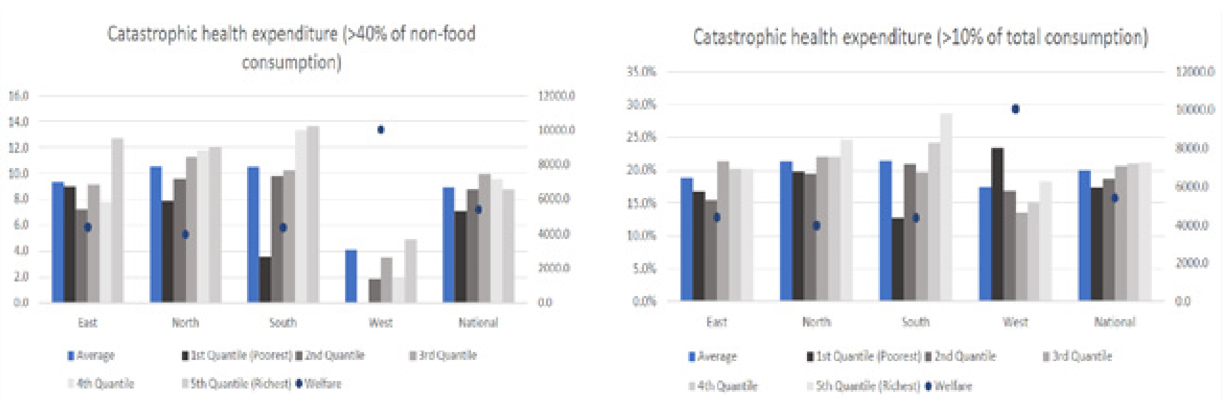
FIGURE 3: TREND IN CATASTROPHIC HEALTH SPENDING IN SIERRA LEONE 2003-2018



Source: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-with-household-expenditures-on-health-greater-than-10-of-total-household-expenditure-or-income-(sdg-3-8-2)-(-)

In addition to the official SDG definition of catastrophic spending, defined using the two thresholds in Figure 3, an alternative approach uses a threshold of spending greater than 40% of non-food consumption, show in the left-hand chart of Figure 4.

FIGURE 4: CATASTROPHIC SPENDING DUE TO OUT-OF-POCKET PAYMENTS IN SIERRA LEONE BY REGION IN 2018

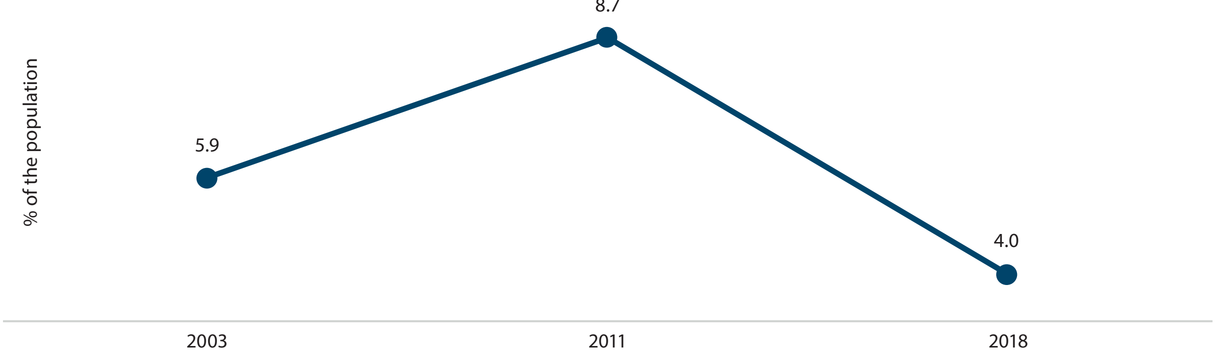


Source: Health financing situation analysis - Ministry of Health and Sanitation January 2020

Whilst not an official SDG indicator, an additional measure of financial protection looks at health spending which leads to impoverishment.

Some people (the poor and the near poor in particular) are not able to spend more than 10% of their household budget on health. Indicators of impoverishing health spending are defined as the proportion of the population pushed and further pushed into extreme poverty (living with less than PPP$1.90 a day person) by out-of-pocket health spending. The figure below only shows the proportion of the population pushed into extreme poverty.

FIGURE 5. INCIDENCE OF IMPOVERISHMENT DUE TO HEALTH SPENDING IN SIERRA LEONE 2003-2018



Source: Global Health Observatory 2021 (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-pushed-below-the-1.90-a-day-poverty-line-by-household-health-expenditures)

HEALTH FINANCING PROGRESS MATRIX: WHERE ARE WE CURRENTLY?

The WHO has developed a Health Financing Progress Matrix, for countries to assess how far they have come in preparing their health financing systems to achieve UHC. The assessment includes a landscaping of existing schemes, and 33 questions. The questions are derived from a comprehensive review of research. Each question highlights and issue that research has found to be paramount in order to make progress towards UHC. There is a scoring system attached to it, and recommendations can be made following the assessment.

The MoHS has embarked on the assessment in January. All members of the technical team participated in the webinar provided by WHO on how to fill the progress matrix. The team was headed by the Principal Health Economist and supported by health financing experts from across agencies and partner organizations, some with public health background, some with district setting background, some with clinical background. Over the course of close to two months, the team assessed the situation in Sierra Leone and noted down the findings. In weekly half-day meetings, the team went through the landscaping process in the progress matrix, then through the 33 questions. In case the team was not able to answer sufficiently a question, members were tasked with stakeholder interviews and desk review during the week. After completion, the Health System Strengthening Lead of the WHO office in Sierra Leone provided a first review, followed by a review of a Health Financing Expert of WHO Geneva. The report was thereafter finalized. This report highlights the findings and recommendations, broken down into immediate action, medium term actions and long-term interventions. It complements the Health Financing Situation Analysis, that has been published in 2019, and the yet to be finalized Health Financing Strategy. Information was used from the National Health Accounts 2017-2018 to complete this matrix.

The target audience for this report are government policy makers, especially those involved in making financing decisions, as well as partner organizations supporting progress towards UHC.

33 Questions were answered, and the scores are summarized in the below table. Overall, Sierra Leone reached 50% of a potential total score of 132 points (66 points scored). The best score was achieved for Public Financial Management 65% (13 out of 20 potential points), followed by Health Financing policy, process and governance 55% (6 out of 12 points), Benefits and conditions of access 55% (11 out of 20 points), Revenue raising 45% (9 out of 20 points) and Public Health Functions and programmes 44% (7 out of 16 points). The last positions were occupied by Purchasing and provider payment 42% (10 out of 24 points) and Pooling revenues 40% (8 out of 20 points).

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Using the guidelines to the Health Financing Progress Matrix, the below seven paragraphs summarize the key recommendations that are important for Sierra Leone to make further progress towards UHC. All recommendations are backed by evidence on what other countries needed to do to progress towards universal health care. .

For all the below sections, the recommendations are coming straight from the extensive evidence review that WHO did and documented in the guidebook of the Health Financing Progress Matrix. The recommendations are adapted to the Sierra Leone context. WHO has summarized what works and has worked in other countries with regards to health financing reform in the various areas in order to make progress towards UHC. The way the below recommendations should be read therefore are "based on evidence from other countries, if we implement this, we will make progress towards UHC".

SUMMARY OF FINDINGS AND RECOMMENDATIONS

ASSESSMENT	RECOMMENDATIONS	RATING
HEALTH FINANCING POLICY, PROCESS & GOVERNANCE	1. Frame the health financing strategy around the two key goals for UHC: provision, access and use of quality health services and financial protection for households (to reduce out of pocket payments). This will ensure that the health financing strategy addresses underperformance in those two issues. 2. Re-look at the governance structures in place for accountability, for example: how are Free Health Care beneficiaries able to hold GoSL accountable for delivery (or non-delivery) of services? Is it necessary to create another supervisory body for this? Similarly, think about the other groups covered: how is parliament involved in ensuring GoSL is being held accountable? Demand Side: increase awareness among beneficiaries around the package and entitlements. 3. Ensure that SLeSHI has an independent supervisory body, with strong civil society representation. 4. Publish budget execution reports at least once a year, specifically for health. 5. NHA should be considered and used as essential planning and budgeting tool in the health sector 6. There must be institutionalization of assessing progress towards UHC using the recommended processes and information	PROGRESSING
REVENUE RAISING	1. There must be improvement in tax per GDP ratio by increasing it to correspond to regional norms, to at least 17% of GDP 2. Continue to increase public financing for health (this is the key evidence in health systems performing in terms of UHC). There must be a clear plan with timelines for progressive improvements in public spending on health. 3. SLeSHI needs to recognize the need for continued heavy financing through GoSL (general budget allocations). Payroll taxes are less preferable in countries with high informal sector like SL, as they lead to further inequities and will be limited in scope. 4. SLeSHI should work towards mandatory contribution scheme. Try to avoid voluntary contribution schemes (e.g. private and community-based health insurance with voluntary sign up). 5. Better regulate the private health insurance market and support the development of it. 6. Let all external funding flow through the GoSL budgetary process (on-budget support), to limit duplications and increase efficiencies in processes. Look potentially into a health pool fund for all support. 7. Improve on the MTEF as forecasting method – re-calibrate the SLIMM model, upon which a lot of the predictions are based. 8. Roll out ePETS for all the health MDAs, to speed up budget allocation release and increase transparency. 9. MoF needs to be stricter in staying on-budget, but also release allocations more timely, to ensure people can execute the budget. 10. Public resources are fairly progressive and hence burden the rich more than the poor. Continue implementing GST exemptions for essentials such as rice and remove any fuel subsidies and/or energy subsidies, as they benefit the rich more. Absolutely stop any fossil fuel subsidies (negative effects on top of benefiting the rich more). 11. Design SLeSHI in a progressive way: rich people should pay more than poor. 12. Increase the tobacco taxes significantly, clamp down on smuggling, to increase tax compliance. Consider introducing a sugar-tax. Also consider higher taxes for imported alcohol. Ringfence those earnings for health specifically.	PROGRESSING

ASSESSMENT	RECOMMENDATIONS	RATING
POOLING REVENUES	1. Analyse how much money is flowing through each scheme to how many beneficiaries, to understand inequities and inequalities better. 2. Revise the formula used to allocate health funds for local councils and ensure it takes into account disease burden and poverty levels. 3. Ensure all schemes use DHIS as M&E tool – a unifying patient information system. Improve on DHIS quality and streamline the indicators. Ensure other systems are inter-linked (e.g. iHRIS, Attendance Monitoring System, mSupply, ePETS, eIDSR, etc.) 4. Set up a unified payment system for health service providers – SLeSHI can do that. 5. Strengthen the SleSHI legislative regulations to ensure it serves as a redistribution tool. 6. Consider creating a pooled fund for health, or at least for supply chain (currently 90% funded by donors in various schemes, not coordinated at all).	PROGRESSING ●●●●
PURCHASING AND PROVIDER PAYMENT	WHO says: “The way in which providers are paid is one of the most powerful ways to influence the performance of providers, from several perspectives including the quality and efficiency of services provided.” In Sierra Leone, that means a) how MoHS pays tertiary hospitals and b) how local councils pay secondary hospitals and PHUs. We know that none of this is based on performance, nor does it take into account efforts to improve quality or efficiency of service delivery. 1. Change the way providers are paid: pay for performance, incentivize quality improvements and compensate efficient hospitals. If PBF is introduced, make sure the public financing for hospitals runs through the same channel and it isn’t just a donor-financed project. In the absence of results-based financing, use at least capitation, as this at least captures some of the population health needs. 2. Move away from input-financing. For example, change from a PUSH to a PULL system for the supply chain. 3. In case PBF is introduced: ensure that incentives are balanced in that no specific patient/condition is preferred to another due to financial incentives attached. Make the indicators primary health based, to increase progress towards UHC. 4. Use provider payment and setting the right incentives (potentially even PBF) to address the irrational drug use / over-prescription of drugs, and therefore reduce the burden of payments for clients. 5. Be mindful of over- and under-provision of services when designing the SLeSHI tariffs. Ensure that providers do not cherry-pick clients based on what they get paid for services (e.g. they decide to treat only TB patients as they get the highest premium for it). 6. Pay higher tariffs for high-impact, high-burden disease treatments. 7. Ensure DHIS captures high-quality data. Continue to improve on data submissions and data quality, to ultimately use that system to reimburse providers for each service delivered. Look at options used in Ethiopia (Watsi) as examples on how to design a system that is less fraud prone. Give further authority to hospitals, while ensuring good regulation – they know what they need most urgently and should be allowed to spend all money (including GoSL allocation) in a self-determined way. Consider guidelines, especially for hospitals with weaker management.	PROGRESSING ●●●●

ASSESSMENT	RECOMMENDATIONS	RATING
BENEFITS AND CONDITITONS OF ACCESS	WHO says: "International experience shows that general declarations of UHC or benefit entitlements for the population are not enough to make real progress; in contrast, being explicit and clear about entitlements and any related conditions of access, reduces uncertainty for the population is a move in a positive direction." And further: "Decisions by policy-makers on benefit design i.e. both entitlements and conditions of access, can be one of the most powerful instruments through which health system performance can be improved, especially when realistically aligned with available revenues and coordinated with complementary reinforcing policies such as the development of programme budgets and improvements in strategic purchasing." 1. Make bold decisions and moves towards UHC: for example, provide all primary care for free for anyone, and simplify existing schemes. That would mean, not just free health care for lactating and pregnant women – it would mean free primary care for anyone (which includes all the services that lactating and pregnant women receive now). Similar, that includes all HIV diagnosis and treatment, etc. Ensure that donors are on board with this move and channel their financing that way. 2. Then, once SLeSHI is ready, add on secondary and tertiary care to the insurance benefits package, and move all primary care under SLeSHI, subsidized. 3. Use cost-effectiveness and/or Health Technology Assessments to inform benefits package decisions (both for the revision of the BPEHS, and for the SLESHI benefits package). Consider fiscal space limitations in the development of basic packages – prioritize based on cost-effectiveness. 4. Avoid making similar mistakes with further rollout of FHCI as at the beginning: clearly communicate what type of services school aged children will be allowed to get for free. 5. Ensure that communication on benefits of the existing schemes (FHC for women and children, malaria program, HIV/Aids program, TB program, etc.) are clear and well understood. Patients should know before going to a clinic for treatment if they have to pay or not. 6. Ensure that Standard Charters of hospitals are clearly visible, possibly available online too, and that fees are as standardized as possible. 7. Cost any further benefits package that is designed. This is important – if the entitlements far outweigh the available resources, the benefits package is misaligned and will lead to greater unmet health need and worse financial protection.	PROGRESSING
PUBLIC FINANCIAL MANAGEMENT	1. Look at the recently conducted Public Expenditure Review for recommendations 2. Lobby the MoF for more flexibility in spending the MoHS budget (and other health agencies). Develop the budget in a broad line item way, to increase flexibility of spending within each line. 3. Ensure hospitals get to keep their revenue and do not have to transfer it to central government. 4. Continue the engagement of MoHS in the budget preparation process and give MoHS more decision-making power in prioritizing limited resources. 5. Increase access points to iFMIS in the health-related agencies. Ensure that end-users are able to track their budget execution. 6. Ensure that budget execution rates are published publicly for increased transparency.	ESTABLISHED
PUBLIC HEALTH FUNCTIONS AND PROGRAMME	1. Use the ongoing health financing strategy process to align different vertical programs under a PHC umbrella. Ensure they use the same financial policies and processes as general government financing. 2. Align budgeting processes of the different vertical programs with the government budgeting cycle. 3. Budget for emergencies as part of the usual budgeting process, and then make that funding quickly available in case of need. Ensure flexibility in its use, while maintaining the usual auditing requirements. 4. Consider doing a Cross-Programmatic Efficiency Analysis, to identify key inefficiencies and optimize health service delivery across different programs.	PROGRESSING

HFPM STAGE 1 ASSESSMENT

HEALTH FINANCING LANDSCAPE: REDUCE THE FRAGMENTATION

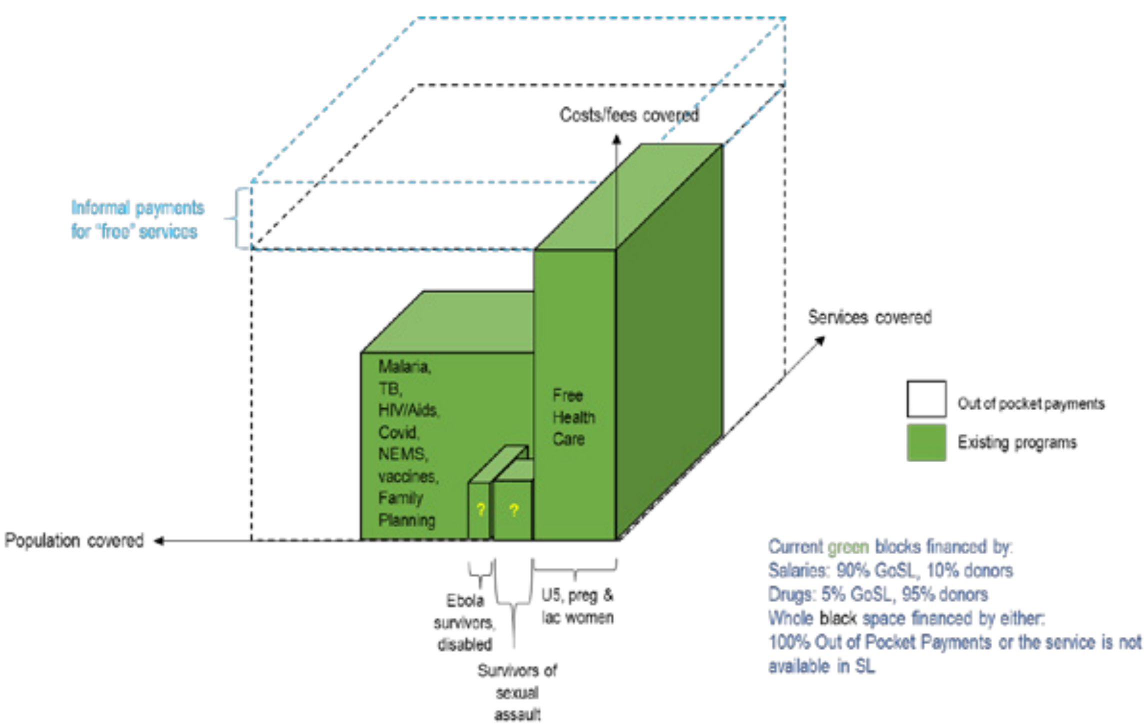
The team identified nine different financing schemes:

1. Government health budget
2. Free Health Care initiative
3. SLeSHI
4. Performance Based Financing
5. School health program
6. Global Fund disease program (Malaria, HIV/Aids, TB)
7. Nutrition
8. Reproductive and Child health (family planning, EPI/Gavi (vaccines), Quality of Care)
9. Private health insurance schemes

The rest is financed through out-of-pocket payments, which are substantial in Sierra Leone. The nine schemes vary in importance – there is very little private health insurance coverage, less than 1% of the population[1], for example, while free health care Initiative (FHCI) provides an extensive package and coverage to targeted population, largely reproductive and child health related, the vertical disease programs similarly provide significant financing and services to the population. Meanwhile, the Performance Based Financing Scheme was significant in the period of 2010-2015, spending USD 15 million in total on the 1200 primary care providers. However, since then, no new scheme has been formulated or implemented. SLeSHI has been under development since 2007, but the scheme is not yet implemented. The final form and shape are currently under discussion. Similarly, with the school health program – there is a policy that is in final format but has not been launched or implemented. The below table summarizes the main schemes currently in place, which therefore are: the government health budget, the Free Health Care initiative and the vertical disease programs (all summarized together, which means Malaria, HIV/Aids, TB, family planning, immunizations, nutrition are captured together). The private health insurance providers have been left out, due to their insignificance. A potential UHC cube for Sierra Leone could look like this[2]:

1 Demographic Health Survey Sierra Leone 2019
2 Please note that this is just for approximate graphic representation, the dimensions are not necessarily in line with actual figures.

FIGURE 6: UNIVERSAL COVERAGE CUBE FOR SIERRA LEONE



For the completion of Stage 1, in which major coverage schemes are described in detail, it was decided to focus on three coverage schemes; vertical programmes were included as one category:

KEY DESIGN FEATURE	GOSL HEALTH BUDGET	FHC INITIATIVE	VERTICAL DISEASE PROGRAMS
A) FOCUS OF THE SCHEME	Provide Essential Health services to all the people of Sierra Leone	To reduce high burden of maternal and child mortality by providing free essential services to all the target population	Coverage under these financing schemes is based on disease – if someone is sick or requires treatment for Malaria, HIV/Aids, TB or severe malnutrition, or is requiring family planning services or vaccinations, they are covered under this financing scheme.
B) TARGET POPULATION	General Population	Under 5 children, Pregnant and Lactating women	People infected with the diseases
C) POPULATION COVERED	Not clear	Target population of Pregnant and lactating women and under 5 children	People diagnosed with the diseases

KEY DESIGN FEATURE	GOSL HEALTH BUDGET	FHC INITIATIVE	VERTICAL DISEASE PROGRAMS
D) BASIS FOR ENTITLEMENT / COVERAGE	All citizens and residents of SL are covered, in all public facilities. In the last 4 weeks, 25% of the population was sick, of which 58% went to seek treatment, of which 75% of people have been using public facilities[3].	Children under 5, pregnant and lactating women are covered. There have been exclamations that Ebola survivors, survivors of sexual violence and the disabled are also entitled to Free Health Care. None of this has been put into a law, it is all based on presidential pronouncements. The total coverage of the "core FHC" covering women and children expands to 2 million people. 81% of pregnant women deliver at public facilities[4], and therefore fall under the FHC initiative.	In terms of numbers, for HIV the population is estimated to be 80,000. The target group for nutrition intervention is 1.2 million in total, the national prevalence rate for severely malnourished children is 1.1% (DHS 2019), which equals just under 40,000 children a year. For family planning, 22.2% of the population are women of reproductive age, with a total demand amongst married women of 46% and an unmet need for family planning of 25%. In absolute numbers, this equals to 1.1 million women demanding family planning and 620,000 having an unmet need for family planning (all data from DHS 2019).
E) BENEFIT ENTITLEMENTS	There is a Basic Package of Essential Health Services 2015, currently under revision. The Package covers primary and secondary services, selected tertiary services. The package has not been fully implemented, as it was never costed, and it is not clear if the government can afford to provide it.	The benefits package under the FHC initiative has never been fully described. It covers either all services as long as the patient is in the target group, or only maternal and child health services, depending on the provider. The services rendered are also depending on service availability.	The services covered are: Malaria testing, treatment and prevention; TB testing, treatment and prevention; HIV/Aids diagnosis, treatment, prevention, IPTI, PreP; health education; CHWs outreach; nutrition screening/ diagnosis, treatment and prevention; childhood vaccines and prevention, HPV vaccine (newly introduced in 2021), Td Vaccine for pregnant women; family planning commodities and counselling.
F) CO-PAYMENTS (USER FEES)	There are user fees for consultations, medication, testing and treatment. No fixed rates in primary care facilities. There are standard charters in secondary and tertiary hospitals, agreed by the hospital management in conjunction with the Health Service Commission that detail the prices for each service.	Officially no co-payments. However, 46% of FHC eligible clients still pay for services.[5]	Officially no co-payments. However, a big part of malaria treatment is provided by the private sector, at profit-making prices.
G) OTHER CONDITIONS OF ACCESS	Services and conditions of access are only valid in public facilities. There is a separate process for overseas medical treatment, where annually between 30-100 citizens benefit from treatment abroad, paid for by the government.	The initiative is implemented in all public facilities, and around 30 NGO/faith-based clinics that signed an agreement to that regard and in return receive Free Health Care drugs. The drugs provided are all generic.	The financing is going largely to public facilities. For the HIV/ Aids service delivery, selected clinics are contracted to provide specialized services. The family planning funding is also running through clinics of Marie Stopes International.

3 Author's calculation, using the Sierra Leone Integrated Household Survey 2018. In absolute figures, this would indicate around 750,000-1,000,000 users a month of the public health system.

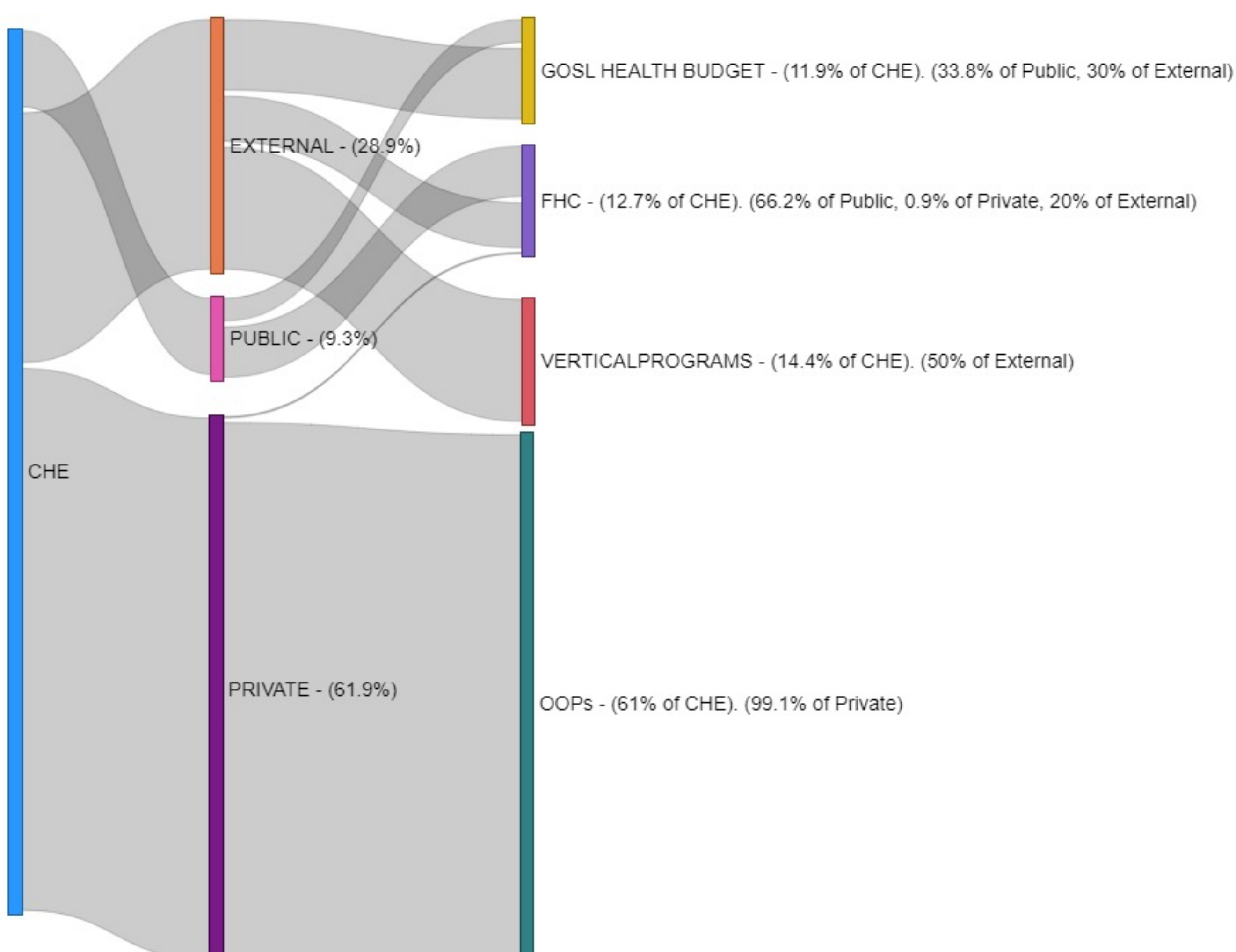
4 Demographic Health Survey 2019

5 Social Accountability Building Inclusion Citizen's Report card 2018. 28% of FHC eligible clients paid for drugs and 18% of FHC eligible clients paid for consultation and other costs.

KEY DESIGN FEATURE	GOSL HEALTH BUDGET	FHC INITIATIVE	VERTICAL DISEASE PROGRAMS
H) REVENUE SOURCES	Financed through GoSL health budget (around LE 400 billion for wages annually and LE 250 billion for recurrent and capital expenditures). Part of the funds go directly to hospitals to pay for diets, cleaning and security services. Part of the funding goes to local councils to decide how to support primary health service delivery. There is general budget support provided by the EU, IMF and other partners, part of which goes to health. There are also numerous off-budget projects that support the GoSL's delivery of the basic package of essential health services.	The salaries for the FHC initiative are largely paid by the GoSL. Drugs are currently only 30% funded compared to annual need, of which FCDO pays 65% and GoSL pays 35%. Other costs are paid for ad hoc – either by GoSL or by partners supporting the GoSL. There is a dedicated and earmarked withholding tax on government contracts of 0.5% of the contract value, that is ringfenced for FHC drugs. That tax has yielded LE 4.5 billion in 2019 and LE 7.3 billion in 2020.	The Global Fund is paying for the majority of costs – including the full annual quantification of drugs required. However, the GoSL has committed to a co-financing of 15% of the Global Fund financing. Nutrition is currently still fully donor funded, but the GoSL has included LE 4.4 billion in the budget for 2022, in order to start contributing to the costs. Vaccines are currently paid by Gavi (routine vaccines) and UNICEF (traditional vaccines), while GoSL contributes around 10% every year. Family planning is fully funded by donor partners.
I) POOLING	Single pool (GoSL)	Multiple pools – GoSL and partners are not pooled together	Multiple pools – no pooling among partners, or between partners and GoSL
K) PROVIDER PAYMENT	Ministry of Health and Sanitation and various subvented agencies (National Medical Supplies Agency, Pharmacy Board, Health Service Commission, Teaching Hospital Board, Postgraduate College Board, Nursing Board, National Aids Secretariat); Sierra Leone Medical and Dental Association; Local councils.	MoHS, NMSA, Local councils, District Health Management Teams	MoHS, National Aids Secretariat, Catholic Relief Services (Malaria), NMSA, Scaling Up Nutrition Secretariat, UNICEF (EPI and nutrition), WHO (EPI), UNFPA (Family Planning), Marie Stopes International (Family Planning)
K) PROVIDER PAYMENT	Primary care providers do not receive any cash, only inputs (staff, drugs, equipment). Secondary hospitals receive an allocation based on a formula including capitation, utilization and poverty levels. Tertiary hospitals receive a budget line item for diets, cleaning and security, and inputs such as drugs, staff, equipment.	No provider is paid for providing free health care services, but they receive drugs and staff and training. During the time of PBF until 2015, the incentives were compensating for the loss of income for providing free services.	Providers do not receive any cash, just inputs (commodities, staff, training, equipment, lab items, etc.)
L) SERVICE DELIVERY & CONTRACTING	Public facilities (with no authority), covering all levels of care (primary, secondary, tertiary).	Public facilities (with no authority), covering all levels of care (primary, secondary, tertiary). There are also selected private facilities (not for profit) that are implementing the scheme.	Public facilities (with no authority), covering all levels of care (primary, secondary, tertiary). Also selected private facilities (not for profit), that are contracted.

HEALTH EXPENDITURE BY STAGE 1 COVERAGE SCHEMES

FIGURE 7: EXPENDITURE FLOWS BY SCHEME (SANKEY DIAGRAM)



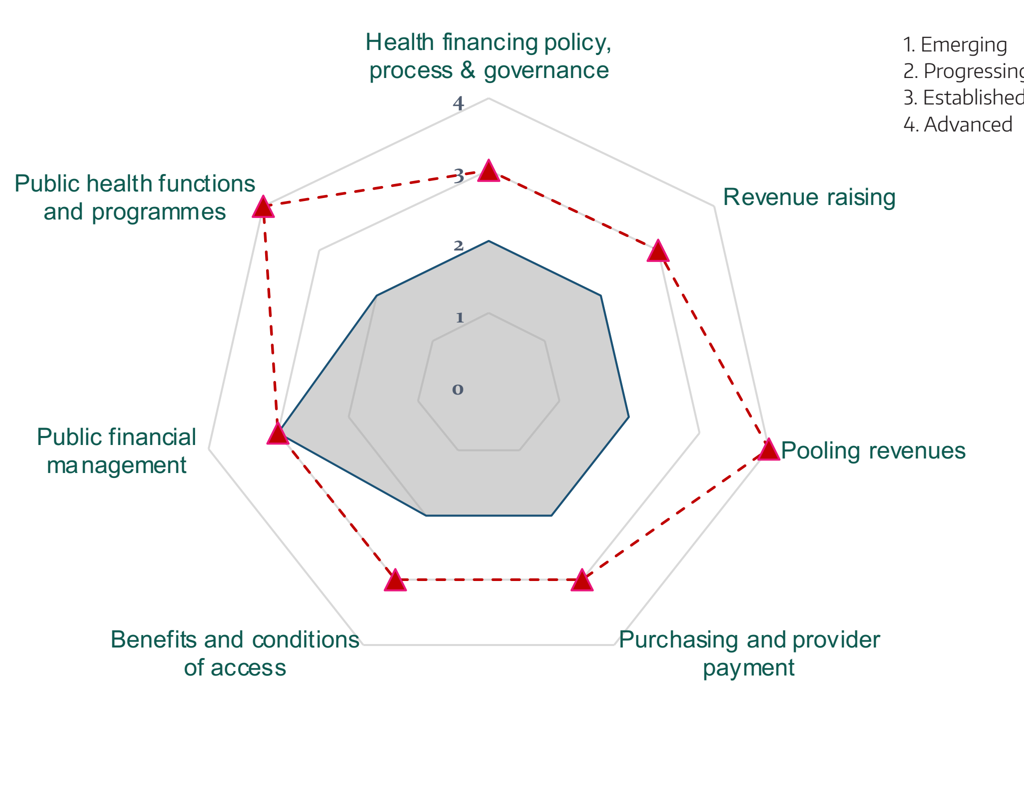
Source: Author elaboration based on the HFxFS Matrix for Sierra Leone National Health Accounts 2018

HFPM STAGE 2 ASSESSMENT

SUMMARY OF RATINGS BY ASSESSMENT AREA

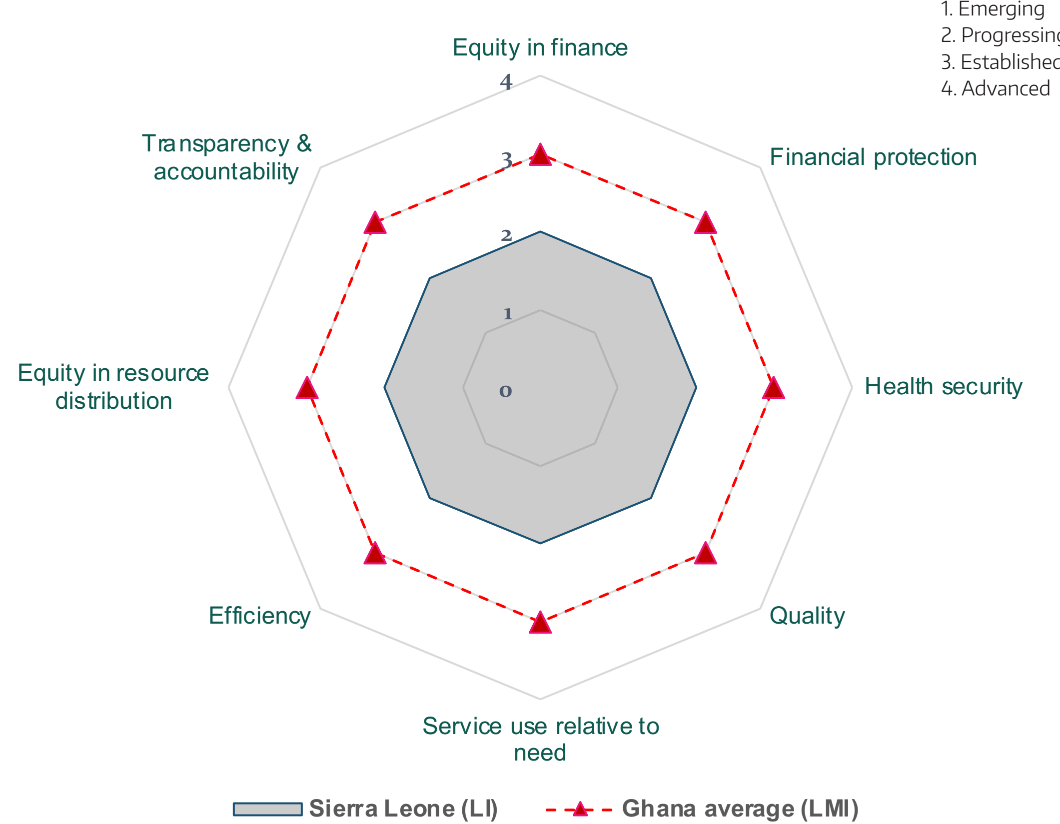
Figure 8 compares HFPM scores in Sierra Leone, a low-income country (LIC), with those of Ghana, a wealthier country defined as lower-middle income, and also in West Africa. Comparisons can be done in different ways; in this case comparing with Ghana means looking at a country with what is generally considered a more developed health system. Looking at the results, Ghana scores higher than Sierra Leone on revenue-raising and pooling policies and also on issues related to the alignment of health programmes with the broader health systems. As such, Ghana may offer some insights useful to Sierra Leone being further down the road. However, countries with higher levels of funding do not automatically mean it has better policies, and it is notable that the scores are similar on the PFM questions for both countries. Scores need to be interpreted carefully, given that that cross-country validation of scores was not conducted.

FIGURE 8: AVERAGE RATING BY ASSESSMENT AREA (SPIDER DIAGRAM)



Source: Author elaboration based on HFPM data collection template v2.0, Sierra Leone 2021

FIGURE 9: AVERAGE RATING BY GOALS AND OBJECTIVES (SPIDER DIAGRAM)

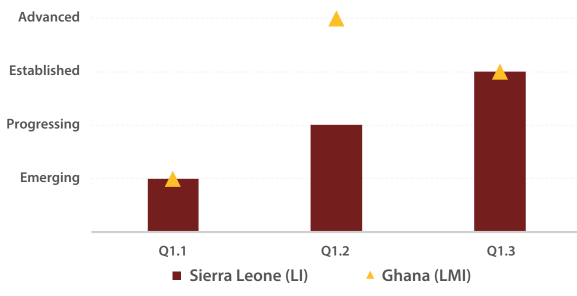


Source: Author elaboration based on HFPM data collection template v2.0, Sierra Leone 2021

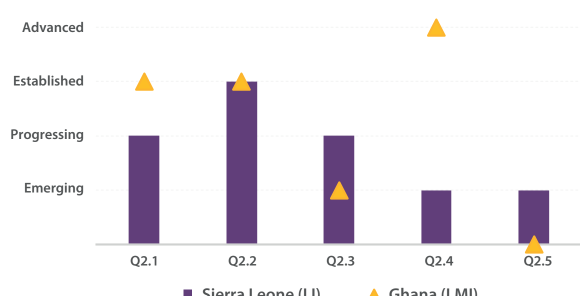
ASSESSMENT RATING BY INDIVIDUAL QUESTION

FIGURE 10: ASSESSMENT RATING BY INDIVIDUAL QUESTION

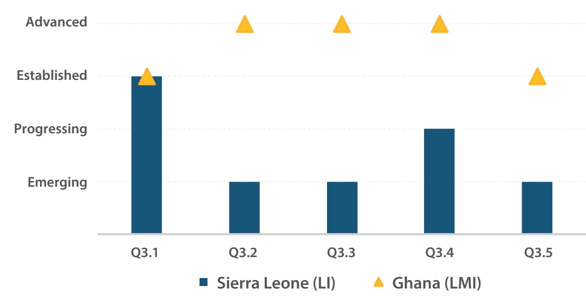
1. HEALTH FINANCING POLICY, PROCESS & GOVERNANCE



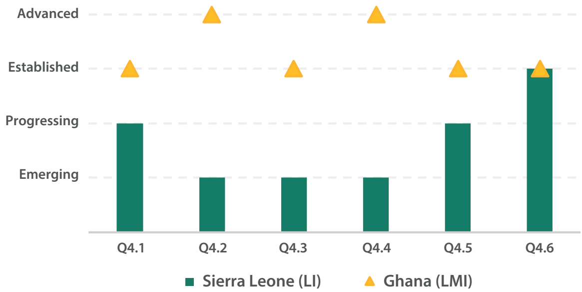
2. REVENUE RAISING



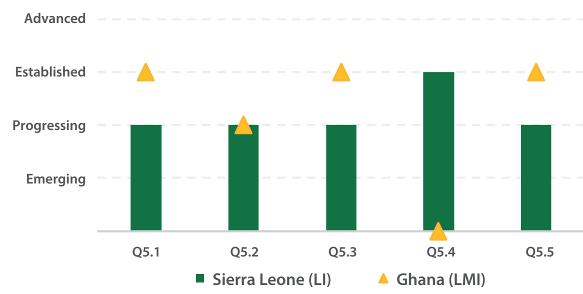
3. POOLING REVENUES



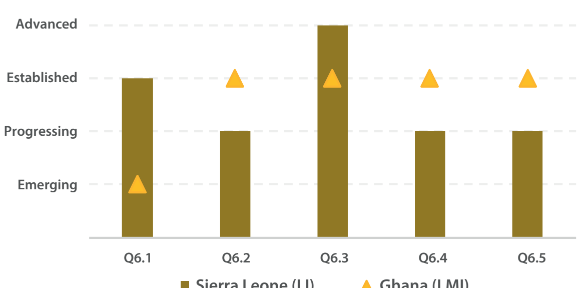
4. PURCHASING AND PROVIDER PAYMENT



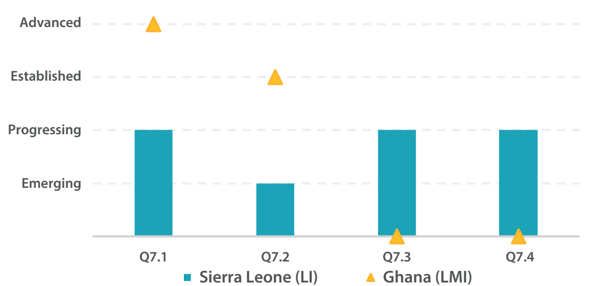
5. BENEFIT AND CONDITIONS OF ACCESS



6. PUBLIC FINANCIAL MANAGEMENT



7. PUBLIC HEALTH FUNCTIONS AND PROGRAMMES

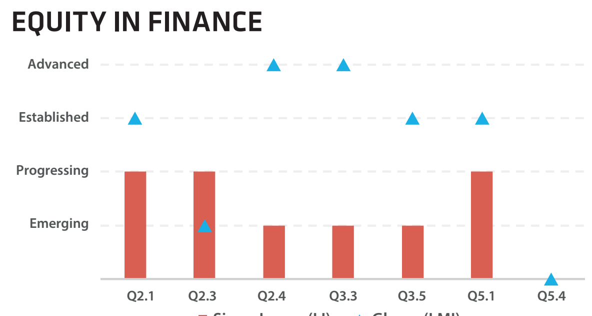


Source: Author elaboration based on HFPM data collection template v2.0, Sierra Leone 2021

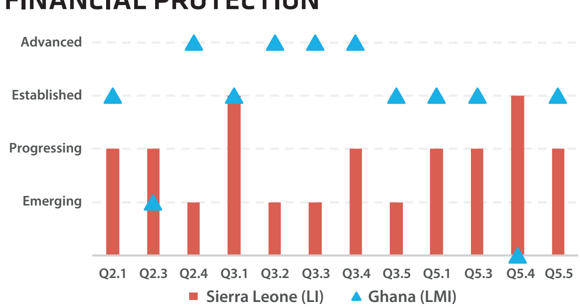
ASSESSMENT RATING BY UHC GOALS

FIGURE 11: ASSESSMENT RATING BY INTERMEDIATE OBJECTIVE AND FINAL COVERAGE GOALS

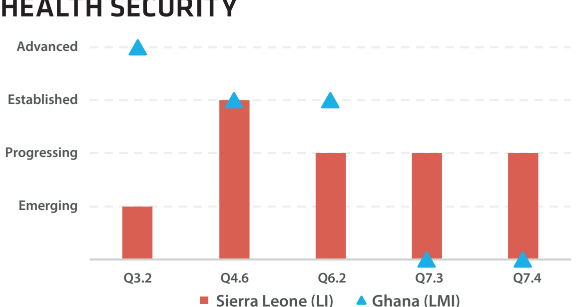
EQUITY IN FINANCE



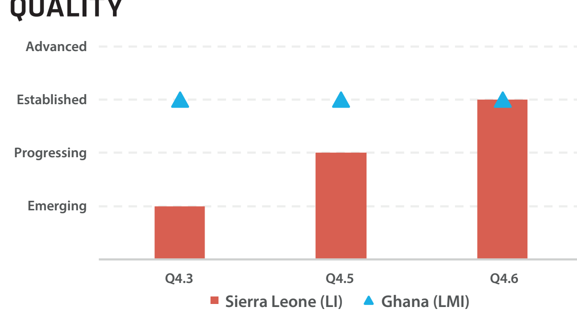
FINANCIAL PROTECTION



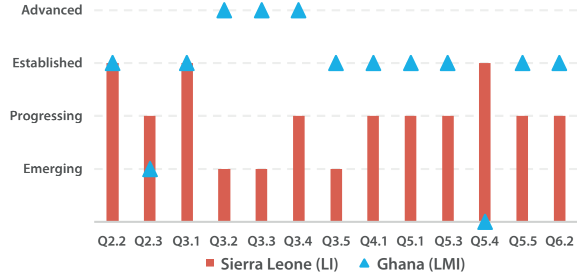
HEALTH SECURITY



QUALITY



SERVICE USE RELATIVE TO NEED



We look at the UHC goals, and these goals are more established in Ghana and in emerging Sierra Leone. Ghana has more transparency and accountability, probably given the existence of established third-party payers, enforcing some level of strategic purchasing in Ghana, Compared with Sierra Leone, where there is less purchaser-provider split in the existing funding mechanism. This trend is also reflected in the other goals, such as financial protection, financial equity, services utilization, health security, quality of care and efficiency, as shown in Figure 9.

Source: Own elaboration based on HFPM data collection template v2.0, Sierra Leone 2021

ASSESSMENT RATING BY INTERMEDIATE OBJECTIVE

FIGURE 11 (CONTINUED): ASSESSMENT RATING BY INTERMEDIATE OBJECTIVE AND FINAL COVERAGE GOALS

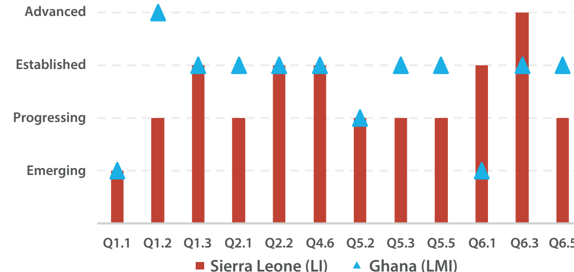
EFFICIENCY

Advanced
Established
Progressing
Emerging
Q3.2 Q3.3 Q3.4 Q3.5 Q4.2 Q4.4 Q4.5 Q4.6 Q6.1 Q6.4 Q7.1
Sierra Leone (LI) Ghana (LMI)

EQUITY IN RESOURCE DISTRIBUTION

Advanced
Established
Progressing
Emerging
Q3.1 Q3.2 Q3.3 Q3.4 Q3.5 Q4.1 Q4.2 Q4.5 Q6.2
Sierra Leone (LI) Ghana (LMI)

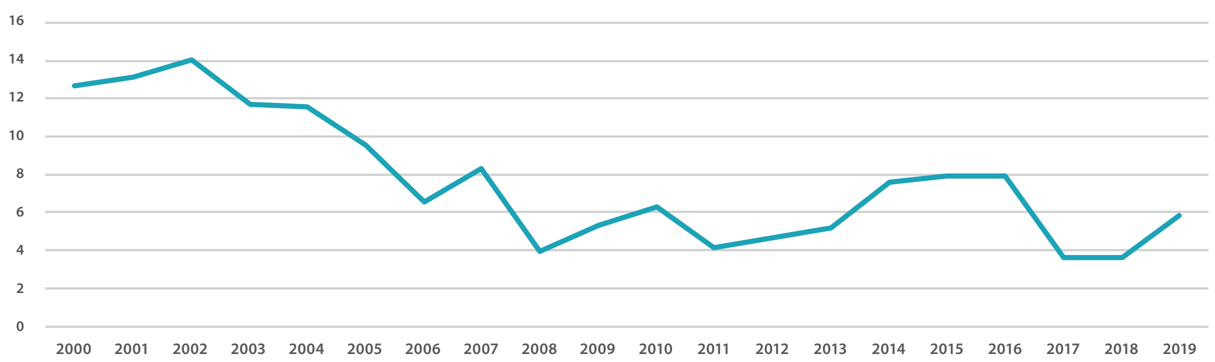
TRANSPARENCY & ACCOUNTABILITY



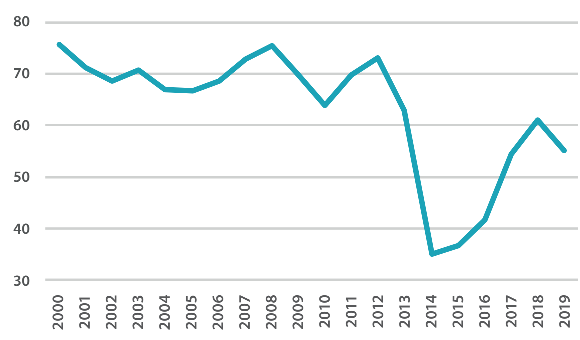
ANNEX 1: SELECTED CONTEXTUAL INDICATORS

FIGURE 12: HEALTH EXPENDITURE INDICATORS FOR SIERRA LEONE

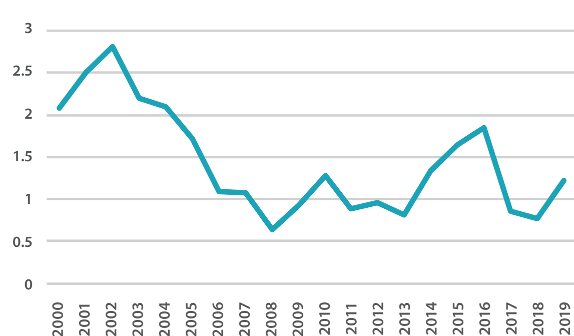
GENERAL GOVERNMENT EXPENDITURE (GGE%GDP)



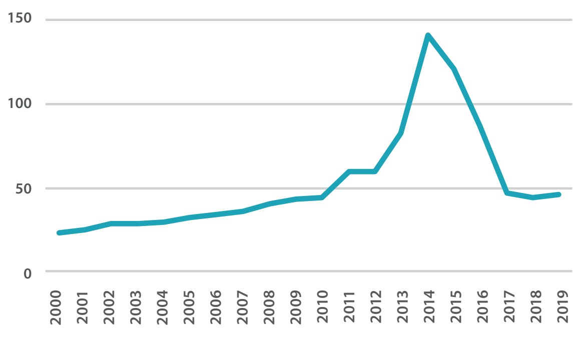
OUT OF POCKET SPENDING (OOPS%CHE)



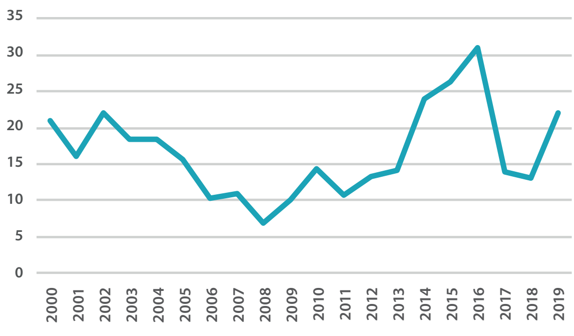
PUBLIC SPENDING ON HEALTH AS % GDP (GGHE-D%GDP)



TOTAL HEALTH SPENDING (CHE PER CAPITA USD)

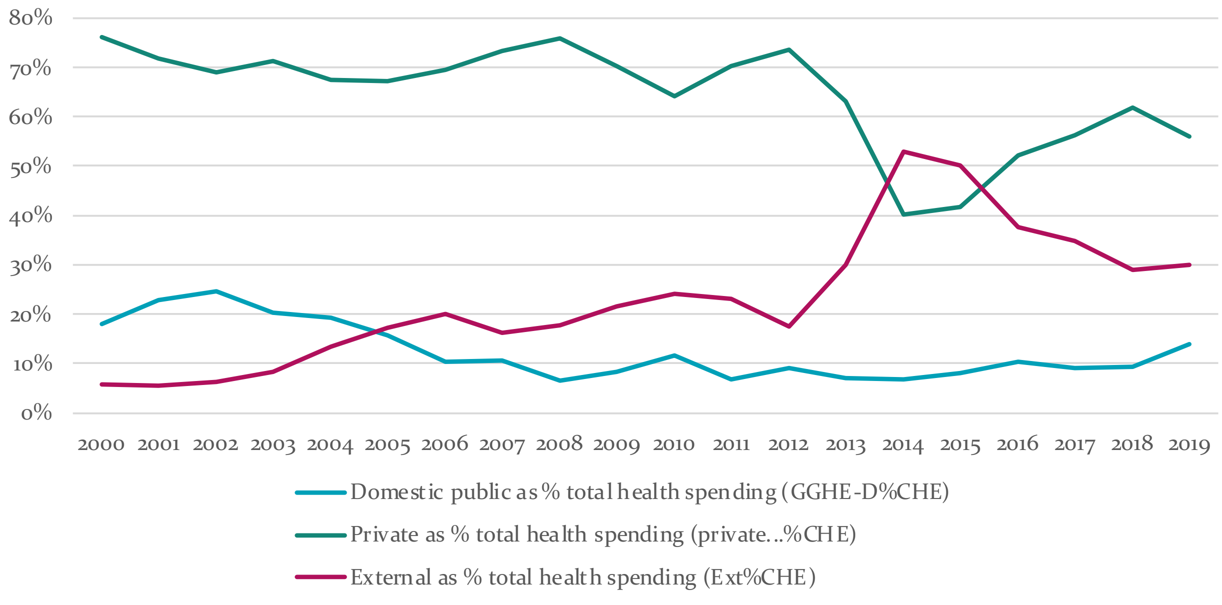


GGHE P.C.

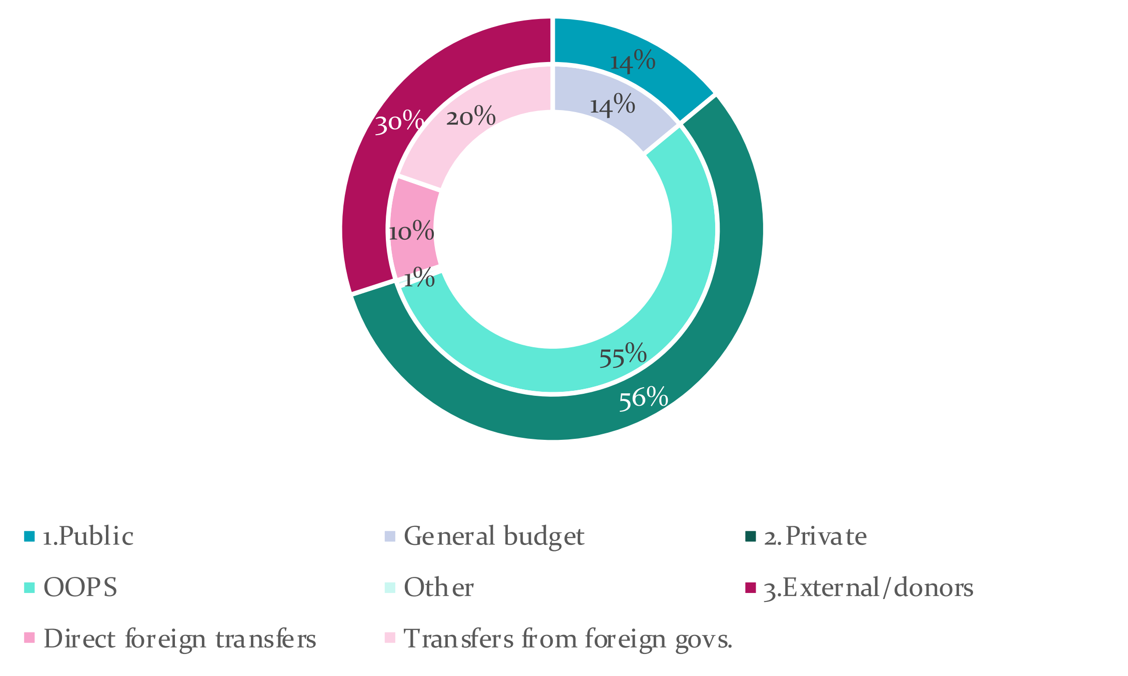


Source: WHO Global Health Observatory, 2021 (https://apps.who.int/nha/database/Home/Index/en)

FIGURE 13: REVENUE SOURCES FOR HEALTH IN SIERRA LEONE



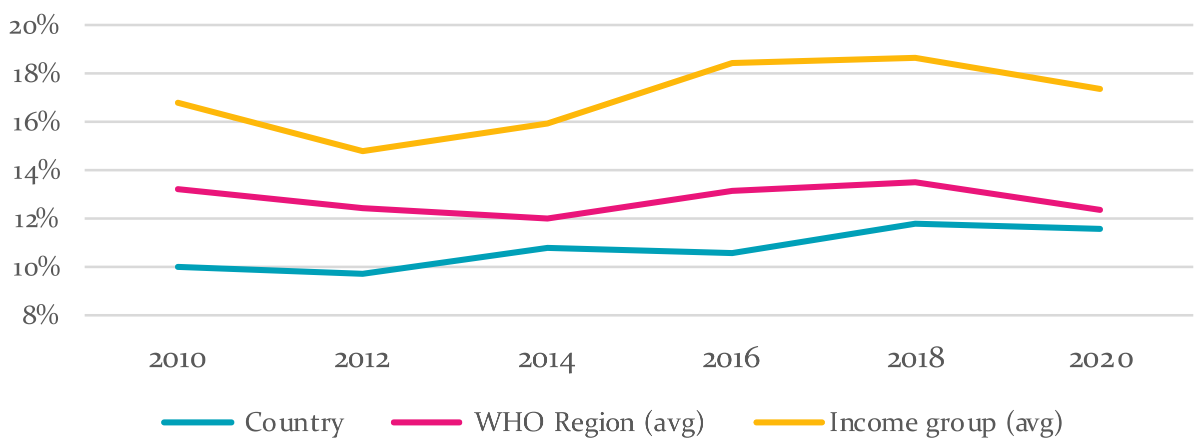
Source: The Global Health Observatory, 2021 (https://apps.who.int/nha/database/Home/Index/en)



Source: WHO Global Health Observatory, 2021 (https://apps.who.int/nha/database/Home/Index/en)

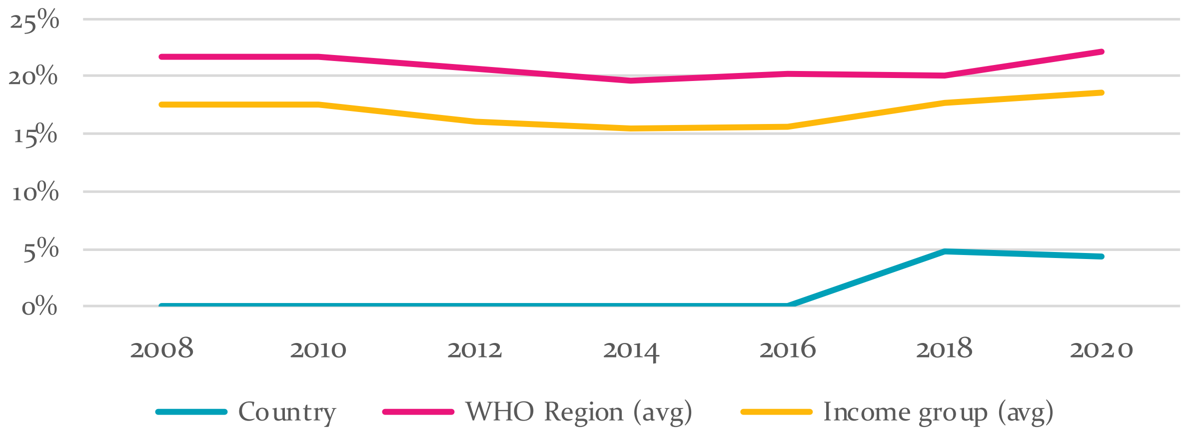
HEALTH TAXES

FIGURE 14: CIGARETTE AFFORDABILITY IN SIERRA LEONE



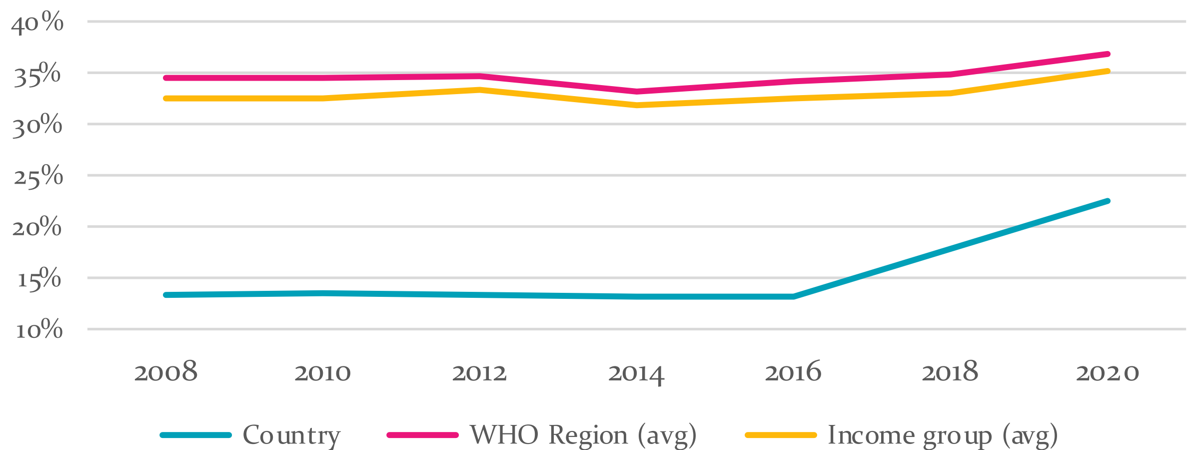
Source: WHO report on the global tobacco epidemic 2021 (https://www.who.int/publications/i/item/9789240032095)

FIGURE 15: EXERCISE TAX SHARE IN SIERRA LEONE



Source: WHO report on the global tobacco epidemic 2021 (https://www.who.int/publications/i/item/9789240032095)

FIGURE 16: TOTAL TAX SHARE IN SIERRA LEONE



Source: WHO report on the global tobacco epidemic 2021 (https://www.who.int/publications/i/item/9789240032095)

ANNEX 2: DESIRABLE ATTRIBUTES OF HEALTH FINANCING

Table 1: Desirable attributes of health financing systems

Health financing policy, process & governance	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies for both individual and population-based services
	GV2	There is transparent, financial and non-financial accountability, in relation to public spending on health
	GV3	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments
Revenue raising	RR1	Health expenditure is based predominantly on public/compulsory funding sources
	RR2	The level of public (and external) funding is predictable over a period of years
	RR3	The flow of public (and external) funds is stable and budget execution is high
	RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms
Pooling revenues	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Purchasing & provider payment	PS1	Resource allocation to providers reflects population health needs, provider performance, or a combination
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Benefits & conditions of access	BR1	Entitlements and obligations are clearly understood by the population
	BR2	A set of priority health service benefits within a unified framework is implemented for the entire population
	BR3	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments
	BR4	Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers
	BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups
Public financial management	PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
	PF2	Providers can directly receive revenues, flexibly manage them, and report on spending and outputs
Public health functions & programmes3	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies
	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PF1	Health budget formulation and structure supports flexible spending and is aligned with sector priorities

ANNEX 3: HFPM ASSESSMENT QUESTIONS

ASSESSMENT AREA	QUESTION NUMBER CODE	QUESTION TEXT
1) HEALTH FINANCING POLICY, PROCESS & GOVERNANCE	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
2) REVENUE RAISING	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q2.5	To what extent does government use taxes and subsidies as instruments to affect health behaviours?
3) POOLING REVENUES	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
4) PURCHASING & PROVIDER PAYMENT	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?

ASSESSMENT AREA	QUESTION NUMBER CODE	QUESTION TEXT
5) BENEFITS & CONDITIONS OF ACCESS	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
6) PUBLIC FINANCIAL MANAGEMENT	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.4	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
7) PUBLIC HEALTH FUNCTIONS & PROGRAMMES	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

ANNEX 4: QUESTIONS MAPPED TO OBJECTIVES AND GOALS

OBJECTIVE / GOAL	QUESTION NUMBER CODE	QUESTION TEXT
EQUITY IN RESOURCE DISTRIBUTION	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
EFFICIENCY	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.4	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?

OBJECTIVE / GOAL	QUESTION NUMBER CODE	QUESTION TEXT
TRANSPARENCY & ACCOUNTABILITY	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
SERVICE USE RELATIVE TO NEED	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?

OBJECTIVE / GOAL	QUESTION NUMBER CODE	QUESTION TEXT
FINANCIAL PROTECTION	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
EQUITY IN FINANCE	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
QUALITY	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
HEALTH SECURITY	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

ANNEX 5: REFERENCES

Demographic Health Survey Sierra Leone, USAID and Ministry of Health and Sanitation Sierra Leone 2019

Sierra Leone Integrated Household Survey 2018

Social Accountability Building Inclusion Citizen's Report card 2018.

Sierra Leone Health Financing Situation Analysis 2019, MoHS

Sierra Leone National Health Accounts 2017/2018

Basic Package and Essential Health Services by the ministry of health and Sanitation 2015

Overseas Medical Treatment Report, office of the Chief Medical Office, 2019

Service Availability Readiness Assessment 2018

Presidential announcement on Free Health Care Initiative in September 2009

Rapid assessment of district's financial management capacity 2020, MoHS

Jowett M, Kutzin J, Kwon S, Hsu J, Sallaku J, Solano JG. Assessing country health financing systems: the health financing progress matrix. Geneva: World Health Organization; 2020 (Health financing guidance, no. 8). Licence: CC BY-NC-SA 3.0 IGO. Accessed at: https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix/

World Health Organization 2021. Tracking Universal Health Coverage: 2021 Global monitoring report. Geneva. Accessed at: https://www.who.int/publications/i/item/9789240040618

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