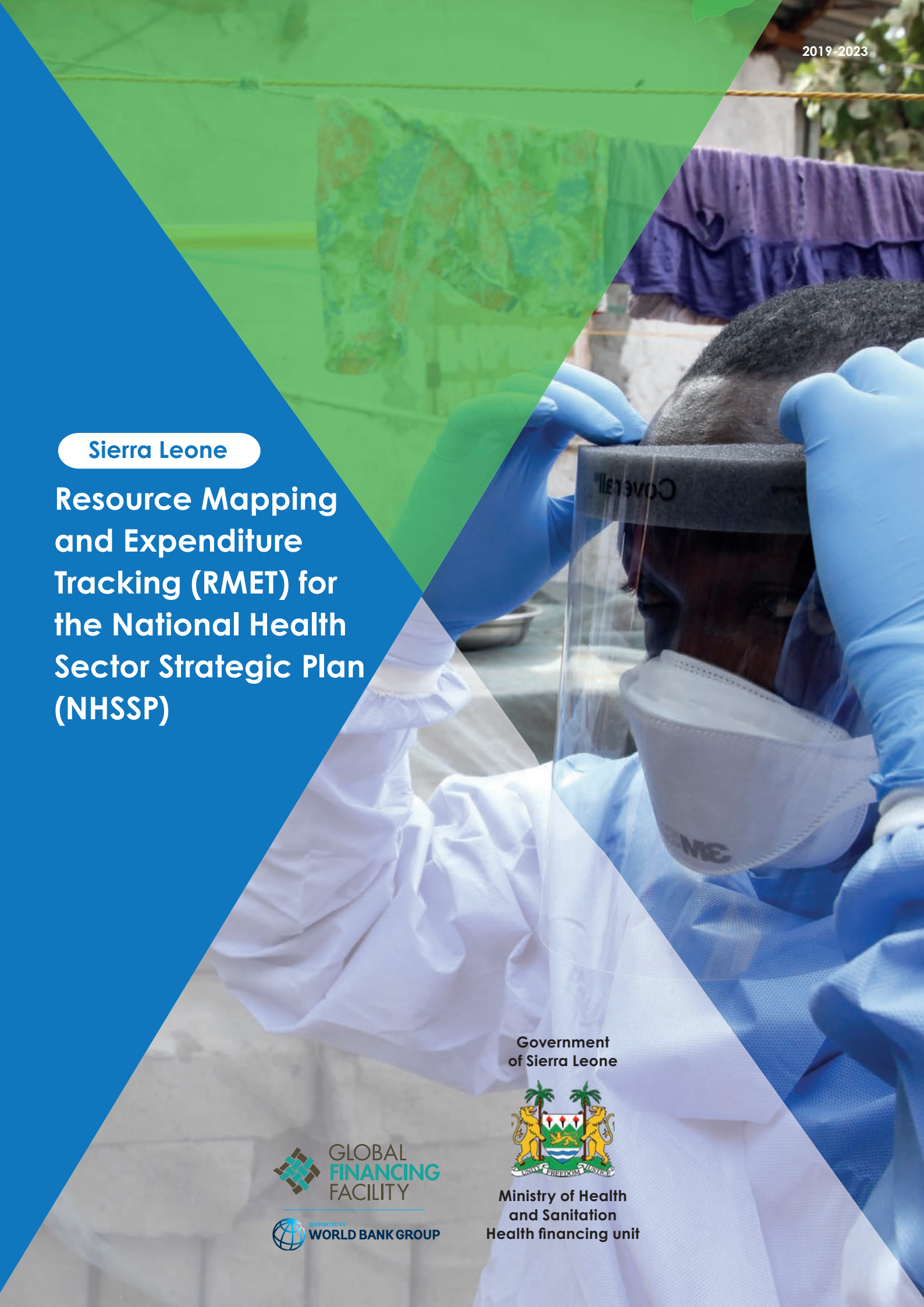
2019-2023

Sierra Leone

Resource Mapping and Expenditure Tracking (RMET) for the National Health Sector Strategic Plan (NHSSP)



GLOBAL FINANCING FACILITY

SUPPORTED BY WORLD BANK GROUP

Government of Sierra Leone

Ministry of Health and Sanitation
Health financing unit

Abbreviations

CDC	Centers for Disease Control and Prevention
CHCs	Community Health Centers
CHPs	Community Health Post
DPs	Development Partners
DFR	Directorate of Financial Resources
EPHS	Essential Package of Health Services
FCDO	Foreign Common Wealth and Development Office
FHCI	Free Health Care initiative
GAVI	Global Alliance for Vaccines and Immunization
GF	Global Financing
GIZ	Gesellschaft für Internationale Zusammenarbeit
GoSL	Government of Sierra Leone
HH	Household
HRH	Human Resources for Health
IsDB	Islamic Development Bank
Le	Leones
Mn.	Million
MoF	Ministry of Finance
MoHS	Ministry of Health and Sanitation
NHA	National Health Accounts
NHSSP	National Health Sector Strategic Plan
OOPS	Out of Pocket
PHUs	Peripheral Health Units
RMET	Resource Mapping and Expenditure Tracking
SLL	Sierra Leone Leones
SSL	Statistics Sierra Leone
THE	Total Health Expenditure
USAID	United States Agency for International Development
USD	United States Dollars
WB	World Bank
WHO	World Health Organization

Foreword

The focus of the Government of Sierra Leone (GoSL) and Ministry of Health and Sanitation (MoHS) National Health Sector Strategic Plan (NHSSP) 2021-2025 is that **"all people in Sierra Leone have access to affordable quality health care services and health security without suffering undue financial hardship."** The NHSSP 2021-2025 provided a costed plan for the health sector and noted that the Sierra Leone health system is under-resourced; therefore lack of financing is a barrier to the execution of the NHSSP.

In a situation of limited resources, coordination and efficient allocation is crucial. However, both coordination and efficient allocation, facilitated by the NHSSP, require data evidence that is not readily available: for example, off-budget donor financing is not routinely tracked in detail, and GoSL budget documents do not provide details by NHSSP policy objective. For this reason, the MoHS health financing unit, with support from technical consultants, Global Financing Facility, and World Bank, decided to lead a resource mapping and expenditure tracking (RMET) study for the Sierra Leone health sector.

This RMET report is theresult of RMET second wave, after the first RMET exercise was conducted in 2021. Its objective is to provide evidence-based recommendations for development partners (DPs) and MoHS, to improve alignment and coordination towards the implementation of the MoHS National Health Sector Strategic Plan priorities, following a One Plan, One Budget, One Monitoring framework.

We acknowledge the financial and technical support provided by the World Bank. Global Financing Facility and other development partners for the successful completion of this RMET study.

Dr. Austin Demby
Minister of Health and Sanitation
January 2023

Table of Contents

List of tables

List of figures

Executive summary

The vision of the Government of Sierra Leone (GoSL) and Ministry of Health and Sanitation (MoHS) reproductive, maternal, neonatal, child and adolescent health (RMNCAH) Strategy 2017-2021, which is the GFF Investment Case (IC) for Sierra Leone, is to achieve "zero preventable maternal, neonatal and adolescent deaths".

However, lack of adequate financing is a barrier to the execution of the RMNCAH Strategy. In a situation where available financing is limited, ensuring that the limited financing available is spent well is crucial: for this reason, the MoHS health financing unit (HFU) decided to lead the RMNCAH resource mapping and expenditure tracking (RMET) exercise. Its overarching objective is to improve coordination and resource allocation across MoHS and donor partners. The RMET delivers findings related to whether adequate financing is available, whether planned resources were executed, and the impact of Covid-19 on RMNCAH financing.

The total NHSSP 2019-2023 financing gap is large at 15% of the total cost (730m US$). However, more comprehensive costing of NHSSP and EPHS is required to complete an appropriate financial gap analysis. Current financial gap is likely to be under-estimated because costs are likely lower than what they really are.

Health financing schemes and investments to PHC should be supported. An example is the direct facility financing initiated this year by the Ministry of Finance. Specific efforts for HSS coordination should be undertaken (e.g., further deep dives and discussions on HSS funding across DPs). In the medium term, pooled funding for free PHC under SLeSHI should be considered.

While PHC investment is increasing, it is important that financing to districts and central level is well coordinated and equitable. While high-level coordination (i.e., major DPs projects are largely happening in different district, so that all major programs together cover the entire country) is happening, per capita funding levels show some substantial disparities across districts. Within districts, the MoHS might want to consider nominating a "lead donor" that will then coordinate and facilitate donor-government coordination in the district, and be a single point of contact for District Health Management Teams.

Given low budgets, every dollar available should be spent. MoHS could focus DPs capacity building investments on PFM and execution of DPs funds. Better execution can also be used to advocate for additional funding both from donors and Ministry of Finance.

There is a lot we do not know yet. Quality of data and response rates should be a priority for next RMET waves. It is very hard for the MoHS and DPs to coordinate efforts if there is no shared knowledge about the activities and investments of major Sierra Leone development partners (i.e., FCDO and USAID). Similarly, the quality of district-level data was very limited: again, understanding how much budget or expenditure per capita is hard when the data shared is not fully reflecting activities in the district.

As we completed this second exercise, we keep on building the capacity of the MoHS in health financing and resource tracking for the health sector, with a view of institutionalizing the exercise in the next few years.

I. Introduction

The vision of the Government of Sierra Leone (GoSL) and Ministry of Health and Sanitation (MoHS) National Health Sector Strategic Plan (NHSSP) 2021-2025 is that "all people in Sierra Leone have access to affordable quality health care services and health security without suffering undue financial hardship."
The health system of Sierra Leone is largely financed by out-of-pocket (OOP) health expenditure and donor partners. In 2018, GoSL accounted for 9.8% of total health expenditure (THE), while OOP and donors accounted for 44.8% and 25.7%, respectively. The NHSSP 2021-2025 provided costing for the health sector and noted that the Sierra Leone health system is under-resourced. As a result, policy makers and stakeholders in the health sector are aware of the importance of tracking resources in the health sector, so that the resources available can be used efficiently.

Given the limited resources and fragmented landscape just noted, the core challenge for the MoHS and the Sierra Leone health system is to spend these resources in a very efficient way that ensures equitable access to quality services to its population. Two interventions, among others, that facilitate greater efficiency are coordination across MoHS and donor partners, and efficient allocation of resources, across policy objectives and geographical areas. The NHSSP aims at improving both coordination and efficiency, by "providing a coherent framework to drive health sector coordination through the next five years", and having as an overall strategic result an "efficient, effective and accountable health system" (cite the NHSSP). However, both coordination and efficient allocation, facilitated by the NHSSP, require data evidence that is not readily available: off-budget donor financing is not routinely tracked in detail, and GoSL budget documents do not provide details by NHSSP policy objective. For this reason, the MoHS health financing unit, with support from technical consultants, GFF and World Bank, decided to lead a resource mapping and expenditure tracking (RMET) study for the Sierra Leone health sector.

The 2019-2023 RMET exercise was completed in December 2022 with a dissemination event in Freetown. It is the second RMET exercise, after the first wave of RMET was completed in December 2021. The exercise was undertaken exactly with the objective of providing a picture of health financing flows into the Sierra Leone health sector and answer a series of policy questions, providing the evidence and data needed to inform policy and budget planning for the MoHS and development partners, with the ultimate goal of improving coordination and efficiency.

II. Objectives

The RMET objectives have been defined by the MoHS Health Financing Unit, and have been organized as policy questions, as shown in the tables below. It should be noted that the three policy questions used in RMET Wave 1, completed in 2021, were all kept for this wave. In addition, this year, a district-related objective has been added.

Table 1

Policy questions and objectives from RMET wave 1

POLICY QUESTION		OBJECTIVE; HOW INFORM POLICY (EXAMPLE)	WHEN INFORM POLICY
Q1	**What is the overall NHSSP funding gap?**	Strengthen advocacy, and inform planning: overall gap used to mobilize and plan resources	During budget hearing, MoHS may use gap to strengthen its case with MoF
Q2	**Which NHSSP priority is under- or over-funded (duplications?)**	Improve allocations: budget may be moved from overfunded priorities to underfunded priorities	During MoHS budget preparation stage, and anytime budget decisions are taken for donors
Q3	**What were NHSSP execution rates of past budget?**	Improve execution: expenditure used to review why programs did not spend	During program evaluations
Q4	**What activities, by district, are being supported by whom?**	Ensure that HDPs are geographically well-coordinated	During planning across HDPs (e.g. GF; FCDO, Gavi, USAID, WB)

Two notes must be made. First, as noted in the next section, the objectives and priorities of the NHSSP are reflected in the data collected for the RMET: all financing flows have been mapped to NHSSP priorities. Second, an additional research question was related to Global Fund RSSH priorities: data was collected with the specific intent of providing a deep dive on those priorities, which was produced in January 2023.

III. Methodology

The methodology used in the implementation and completion of the RMET 2018-2022 is largely based on a standardized tool which was adapted to Sierra Leone MoHS priorities and can be summarized in the following four key steps:

1. Standardized data collection template, adapted to Sierra Leone MoHS priorities, sent to all DPs and MoHS to map resources. For MoHS, data from boost and budget documents was used.
2. Collected budget (2019 – 2023) and expenditure (2019 – 2021) data from donors, and MoHS. Note that with "MoHS" we mean all government health sector entities (NMSA, commissions, professional boards, etc.), beyond MoHS only.
3. Shared data was cleaned and reviewed. Follow-up meetings were completed if needed.
4. Finalized data from each entity was compiled and analysed.

3.1. Preparation

During this phase the scope of the study was agreed. All development partners (DPs) involved in the exercise and various UN agencies (UNFPA, UNICEF, WHO) were involved in the kick-off session and data collection workshop session held in February and March 2022: during both sessions feedback was received regarding the scope of the study, the data collection tool that will be used and the necessary input and changes adapted from donor and representatives. The kickoff was focused on looking at the scope, roles and focal points including the next steps and timelines of the RMET activity including changes to be adapted.

After kickoff, the scope was agreed as being all DPs (World Bank, Gavi, Global Fund, USAID, FCDO, BADEA, AfDB, GIZ, CDC US, etc.) covering more than 90% of total DPs financing, according to National Health Accounts 2018. While in RMET Wave 1 the data was collected only for the national level, for this exercise the data was collected also for the district level. Data was collected for the period 2019-2023, and with details of NHSSP strategic pillars, and cost category, among others.

In order to fulfill the research question specific to Global Fund Resilient and sustainable systems for health (RSSH), an additional detail on RSSH priorities was collected, following guidance from the Global Fund Health Financing Specialist.

After the kickoff and data collection workshop, the RMET Health Sector data collection tool and its user guide were finalized including all feedback received from DPs and UN agencies. The tool is a standardized RMET tool used in many different countries, adapted to the Sierra Leone context and needs.

3.2. Collection of financial data

For the collection of health sector budget and financial data, the same data collection tool and user guide has been provided to all DPs via email by the MoHS HFU. The same data collection tool was also used by the MoHS HFU to collect GoSL financial data. Once the data was received, individual meetings with HFU staff representatives and donor partners were conducted to complete or better understand the data collected, as needed.

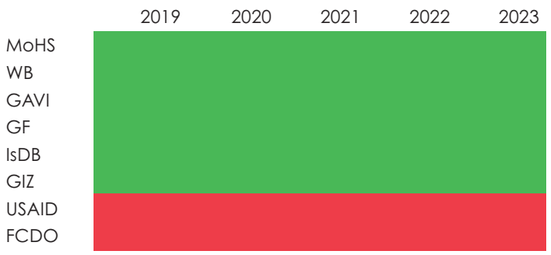
The fact that GAVI, WB, GF, and IsDB programs are largely implemented by MoHS implies that the RMET wave 2 is largely focused on DPs "on budget" financing. For these donors, the main implementer is the MoHS.

Costing for the NHSSP was available for years 2021-2022 from the NHSSP 2021-2025. For the 2018-2020 period, the NHSSP 2015-2020 was not costed. We have therefore made an estimate based on the costing of other strategies (the RMNCAH strategy, the HIV strategy, the Malaria strategy, the HR strategy, etc.) whose costs were provided in the appendix of the NHSSP 2015-2020.

Below we report on the response rates from the main DPs. Several other DPs not noted below have also not replied to requests for data. When all DPs contacted are considered, the response rate has been below 50%.

Table 2

Response rates of main DPs and MoHS, by year



FCDO and USAID did not provide the data.

3.3. Data analysis, data validation and write-up

After cleaning and clarifying outstanding questions regarding the data collected, the data is prepared for analysis. Tables and graphs broken down by NHSSP strategic pillar, cost category, health system level, are then produced. Before report writing starts, a validation session with all entities involved in the data collection (MoHS, Civil Societies representatives, DPs, UN agencies) has been carried out to ensure data and analyses are sound. The study report is finally drawn up based on all comments received during the previous phases of the study.

Two additional points should be noted. First, expenditure data can be shared and re-used, if possible, during the next NHA wave. NHA data has been used when reviewing the contribution of DPs to total health sector financing in previous years. Second, results are available in both SLL and US$, as SLL might be more relevant for the MoHS and US$ might be more relevant for DPs. In this report, we focus on the results in US$.

An understanding of each of the above NHSSP priorities is crucial to the development of an innovative health financing strategy for Sierra Leone.

IV. Results

The results section is organized into five (5) sub-sections, which are closely related to the policy questions presented in the Objectives section.

4.1. Budget and gaps: is adequate financing planned for the overall health sector?

The total NHSSP 2019-2023 budget shows a 15% financing gap, which is rather low and confirming the need for more comprehensive costing of the NHSSP and EPHS. The MoHS is the largest health sector financier.

Figure 1

NHSSP financing gap, across all years, 2019-2023 period

Source: Author

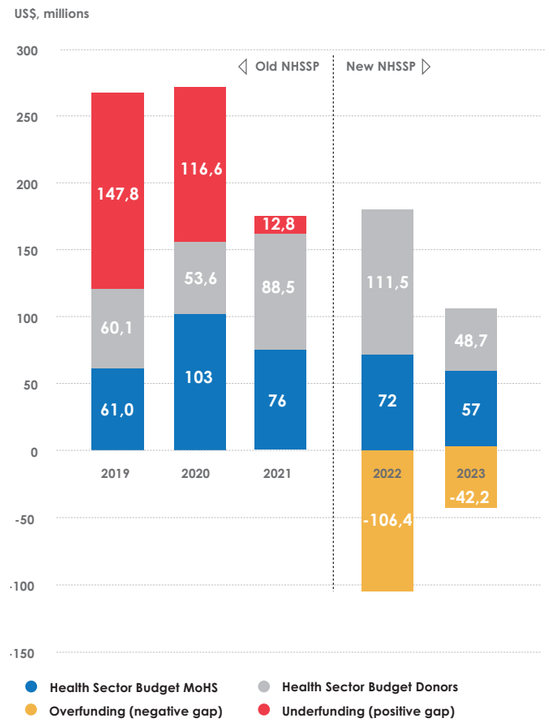
From the figure above, the top three (3) donors' financiers for the health sector are WB, GF and GAVI. All donors combined provide similar funding of the MoHS. However, it should be reminded that we have no data for USAID and FCDO: it is possible that including them may change the result. Once they are included, it is very likely that all donors combined will contribute more than the MoHS.

In RMET Wave 1 the budget gap was larger (~40%), this is because 2018 NHSSP costs are larger than 2023 NHSSP costs, and because of GF and WB updated their budgets with new programs (e.g., World Bank Quality of Essential Services and System Strengthening Project). Because the financial gap is focused in early years (2018-2020, as shown in Figure 2), and the exchange rate is worse in recent years (2022, 2023), when we measure the financial gap in SLL the gap is about half (7%).

Figure 2

NHSSP budget commitments and financing gap, by MoHS and donors, by year, 2019-2023

Source: Author



It appears that the 2021-2025 NHSSP is over-funded, which is not the case: a more comprehensive costing is required. Once a more comprehensive costing is considered, it is very unlikely that the GoSL NHSSP is over-funded. MoHS funding for the health sector is similar or higher to that of all donors combined from 2020, onwards. However, DPs financing in 2021-2022 may be low because donor future budgets are not fully available.

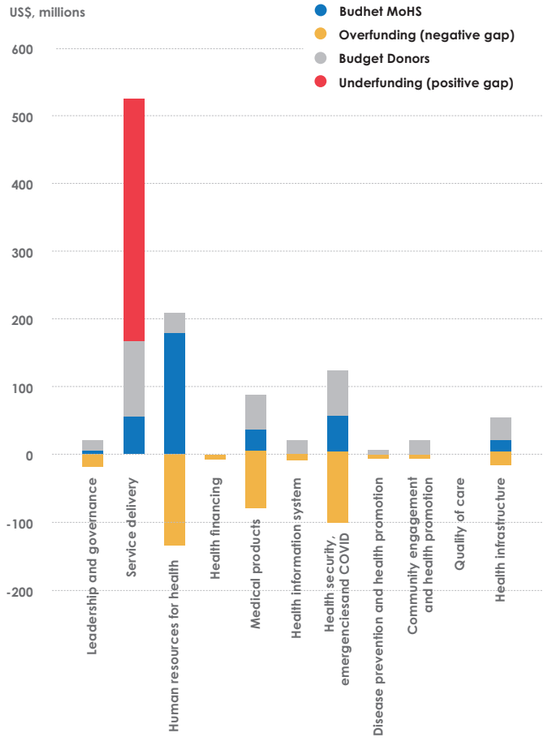
4.2. Budget and gaps: is adequate financing planned across NHSSP priorities?

The only NHSSP priority showing a gap is "service delivery". Comprehensive costing is required across priorities, which are unlikely to be overfunded.

Figure 3

Health sector budget commitments and financing gap, by MoHS and donors, by NHSSP priority, 2018-2022

Source: Author

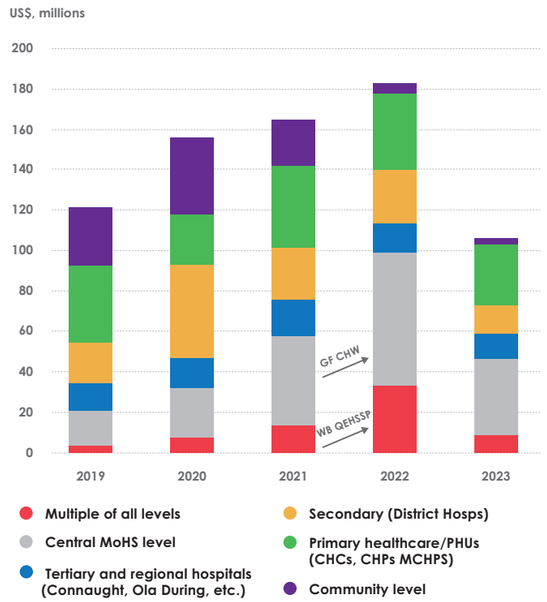


The figure above depicts that service delivery is the only priority showing a gap. However, rather than showing that the NHSSP is well-funded, this shows that a comprehensive costing is required across priorities, which are not overfunded and drugs are largely financed by donors (Global Fund), while the opposite is true for HRH. It is very interesting to point out that the budget for infrastructure and community health appears to be particularly low.

Figure 4

Budget by health system level, total period 2019-2023

Source: Author



From the above figure, the increase in community and PHC spending in 2021-2023 is driven mostly by DPs. Funding for central level MoHS are very large. However, that might be a result of some DPs not knowing exactly where funds are being spent (e.g., GAVI). The MoHS budget that is greater than 50%, devoted to secondary and tertiary care, in the full period. However, this is driven by HR payroll, which might not be 100% up to date.

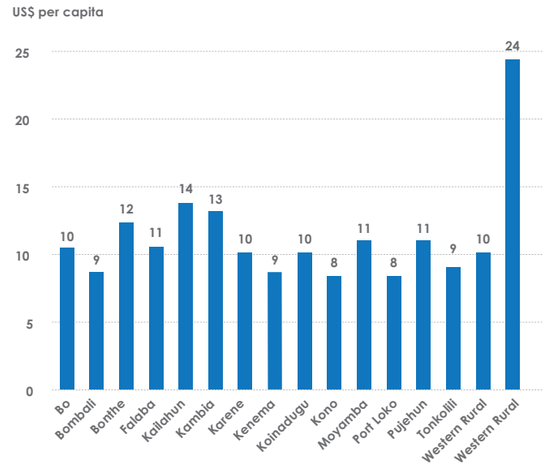
The quality of financing data by health system level has improved from last year, but still has opportunities to improve. Last year most budgets were "multiple or all system levels", which is not the case this year. However, in some cases "multiple all or levels" and "central level" have been used when entities were not sure about the health system level. Central level might be overestimated for this reason.

4.3. Budget across districts: how are budget planned across districts?

Figure 5

Budget by district per capita, total period 2019-2023

Source: Author



Here, it is very important to note that expenditures marked as "central level" (44%) have been excluded from the district-level expenditures. The figure above does not consider other measures except population (e.g., districts area, road availability, morbidity, etc.). **Western Area Urban is a clear outlier district.** Part of the difference might be driven by tertiary services provided to people traveling from other districts.

Financial gap analysis at district level is not possible as NHSSP was not costed by district. The differences across other district might seem small, but they are large in percentage. Kailahun has around double the US$ per capita of Port Loko.

A key question is **what is driving these differences across districts?** We advance some hypotheses:

- MoHS salaries seem to be a substantial source of disparity. Districts seem to have similar investments, favouring smaller districts in per capita terms (see Kambia, Bonthe, Falaba).
- In the case of Kailahun, the presence of WB and GIZ together, on top of GF presence across districts.
- Bonthe, Falaba benefits from both being small and from being WB QEHSSSP districts.
- Kono might look low: we should be mindful that this Wave 2 cover most large donors, but off-budget smaller donors and implementers are not yet included.

In addition to those possible hypotheses, quality and lack of data issues may be at play. Often times, activities clearly attached to districts for which the exact district breakdown was not known were "attached" to the central level, while in other cases the financing across districts was mapped to districts using population breakdown. The impact of these different modalities of assigning financing to districts is different:

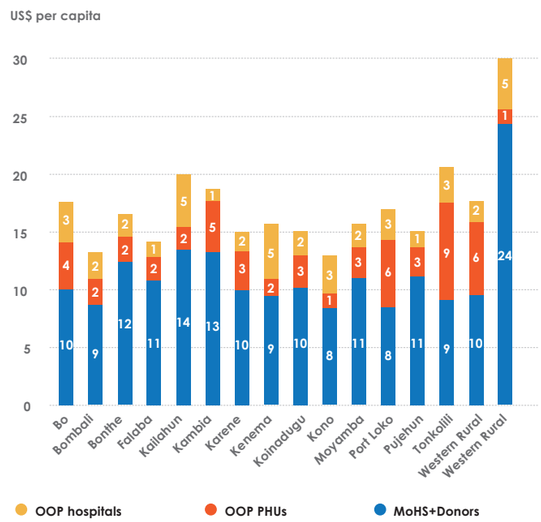
- Case 1: breakdown by district was unknown, and data provider put all financing under "central" Result: the absolute expenditure by district is lower than what it should be.
- Case 2: breakdown by district was unknown, and financing was spread across all districts by population. Absolute levels are ok, but differences across districts would be flattened.

Finally, below we added OOP household expenditures to MoHS and DPs budget.

Figure 6

MoHS, DPs and OOP expenditure by district per capita, average per year

Source: Author



At 6US$ per capita (average), the money paid from patients to providers (as claimed in SLIHS 2018) is substantial, equivalent to 80% of the total MoHS budget. OOP health expenditures are also variable, raising substantial equity concerns for some districts (Tonkolili, Port Loko, Western Area Rural, Kailahun, Bo, and Kenema). Given that part of these internally generated revenues (IGR), especially those from PHUs, are likely not recorded, an IGR policy seems an urgent next step from the MoHS. The graph also shows that, at least for some districts, larger OOP expenditures may offset low support from DPs and MoHS. Except for Kailahun, all districts with above average OOP have below average MoHS plus DPs funding (Port Loko, Western Area Rural, Tonkolili, Bo and Kenema).

4.4. Expenditure: was the planned budget executed?

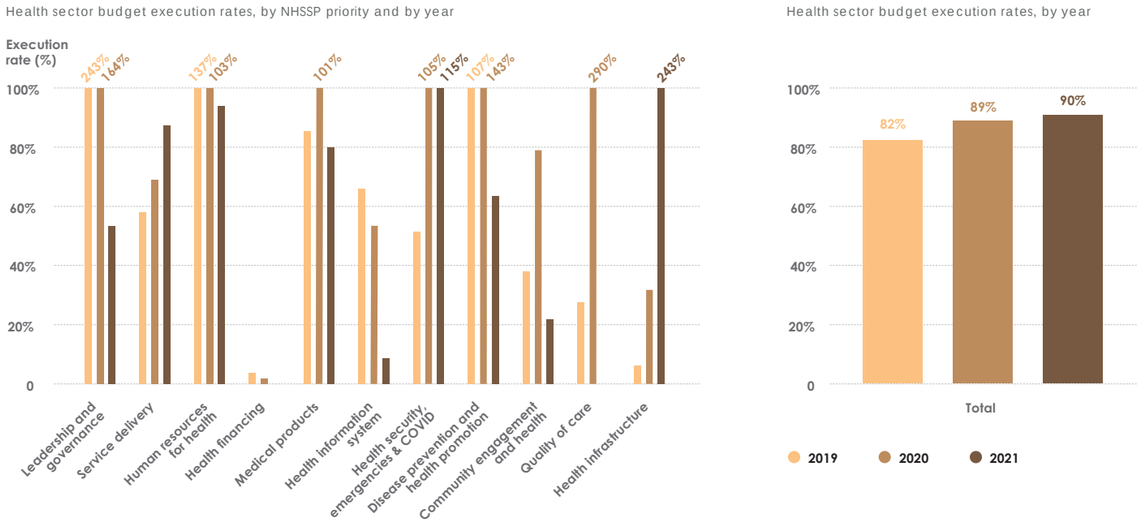
Execution rates are generally growing from 2019 (82%) to 2021 (90%). The trend is generally visible across NHSSP priorities, in particular service delivery and infrastructure.

It is very significant to note here that medical products are well executed by Global Fund, less so by MoHS. MoHS execution rate in 2020 is based on estimated expenditure rather than actual: at the time of data collection, April 2021, actual expenditure was not available.

Figure 7

Execution rates across priorities and years

Source: Author



The below is a mapping of districts support and central level support developed for FCDO that might be useful to others.

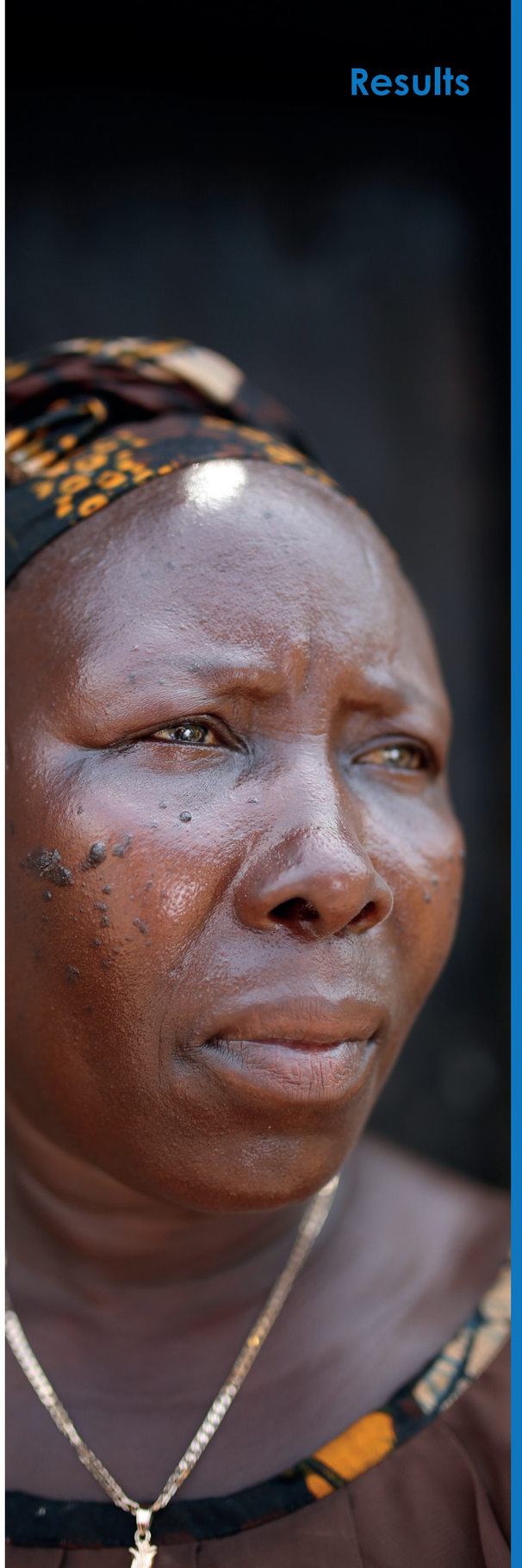
DISTRICT	POPULATION	MAJOR DPs PROGRAMS	COMMENTS / OTHER DONORS
Kailahun	526,379	WB	PMI, WB support tu Hub-and-Spoke facilities, DHMT GIZ supporting DHMT management, HR management, health security
Kenema	609,891	FCDO?	PMI.
Kono	506,100	FCDO?	PMI. Note: support from PIH not included in resource mapping as implementers not yet included
Bombali	606,544	FCDO?	PMI
Falaba	205,353	WB	PMI, WB support to Hub-and-Spoke facilities, DHMT
Koinadugu	409,372	USAID?	PMI
Tonkolili	531,435	WB	WB support to Hub-and-Spoke facililties, DHMT
Kambia	345,474	FCDO?	GIZ supporting DHMT management, HR management, health security
Karene	285,546	USAID?	PMI, IsDB
Port Loko	615,376	USAID?	PMI
Bo	575,478	USAID?	PMI
Bonthe	200,781	WB	WB support to Hub-and-Spoke facilities, DHMT
Moyamba	318,588	FCDO?	IsDB
Pujehun	346,461	USAID?	PMI, IsDB; GIZ supporting HR management, health security (just started)
Western Rural	444,270	WB	PMI partial, WB support to Hub-and-Spoke facilities, DHMT
Western Urban	1,055,964	FCDO?	PMI partial

Notes: support from FCDO and USAID is not conf irmed and noted with question mark. FCDO has been previously supporting all districts via Saving Lives

4.5. Limitations of the analysis

This is the first time this exercise is done since five (5) years and it will hopefully be continued further. It is therefore important to understand opportunities for improvement. The RMET 2018-2022 report has the following key limitations:

- **Appropriate costing for health sector services**: updated comprehensive costing would allow for appropriate gap analysis, planning, and improved resource mobilization. Current financing gap analysis showing over-funding is not realistic.
- **Data was not available for two large donors, FCDO and USAID.** While it is normal that budget for future years is not approved, tentative or indicative budgets are often available. The value of the exercise is severely diminished by the lack of visibility of DPs budget. Therefore, a comprehensive analysis is difficult without these key respondents.
- **There is a bias towards large cost categories and program areas.** Investments are not budgeted or tracked based on MoHS priorities. Therefore, when a budget line would interest more than one priority/health system level/cost category/etc., the budget line was linked to the most important priority/cost category/etc. thus generating a likely bias towards these large priorities.
- **Data across districts and health system level was not always available**, resulting in donors allocating funding to the "Central Level" when in fact funding is going to health service delivery, rather than central level activities. Therefore, there might be an overestimation of central level funding.
- **There is no NHSSP costing by district:** because of this, it is impossible to provide a financial gap for each district.



V. Findings, recommended actions and conclusion

The findings of the exercise, and the recommendations that follow from each finding, are summarized in the below table.

Table 3

Findings and implications/recommendations

Source: Author

FINDINGS AND RELEVANT POINTS	IMPLICATIONS / RECOMMENDED ACTIONS
Completing a financial gap analysis is not possible because NHSSP costing need to be more comprehensive. Current financial gap is certainly under-estimated.	**More comprehensive costing of NHSSP and EPHS, detailed by district,** is required to complete an appropriate financial gap analysis, including at the district level.
PHC financing is growing, largely thanks to DPs. However, PHC financing can and still need to increase, both from DPs and MoHS. A very large part of funding goes to Central Level, but coordination is unclear.	**Health financing schemes and investments to PHC should be supported.** An example is the DFF from the MoF, initiated this year. Specific efforts for HSS coordination should be undertaken (e.g., further deep dives and discussions on HSS funding across DPs). Poolin g could be considered for PHC funding to improve coordination.
District level data shows disparities, especially between Western Area Urban and other districts.	While PHC investment is increasing, it is important that financing to districts and central level is well coordinated. While some high level coordination is happening, per capita funding levels show some substantial disparities. **The MoHS could consider nominating ONE Development partner as the "district lead" in charge of coordinating all development partners in the district.**
Execution rates are improving, but remain below 80% for some DPs, whose funds are executed by MoHS.	Given low budgets, every dollar available should be spent. **MoHS could focus DPs capacity building on PFM and execution of DPs funds.**
Quality of data improved versus last year (see PHC data and district level data), but response rate worsened. The analysis is limited by some DPs not providing data and an overall response rate below 50%. With regards to data quality, some district level data was missing and/or "assumed" to be distributed equally by population.	**Quality of data and response rates should be a priority for DPs for next RMET waves.** The unified PFM system currently being developed at IHPAU should be used by all the on-budget and (when possible) off-budget DPs in Sierra Leone to ensure data flows to the MoHS with appropriate detail to inform policies and improve coordination.

Sierra Leone

Resource Mapping and Expenditure Tracking (RMET) for the National Health Sector Strategic Plan (NHSSP)

2019-2023

GLOBAL FINANCING FACILITY

SUPPORTED BY WORLD BANK GROUP

Government of Sierra Leone

Ministry of Health and Sanitation
Health financing unit

Design: www.pi-marketing-communication.com
Photos: © Dominic Chavez/World Bank