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March 2022

Sierra Leone

Sierra Leone Resource Mapping and Expenditure Tracking for RMNCAH 2018-2022

Government of Sierra Leone

Ministry of Health and Sanitation
Health financing unit

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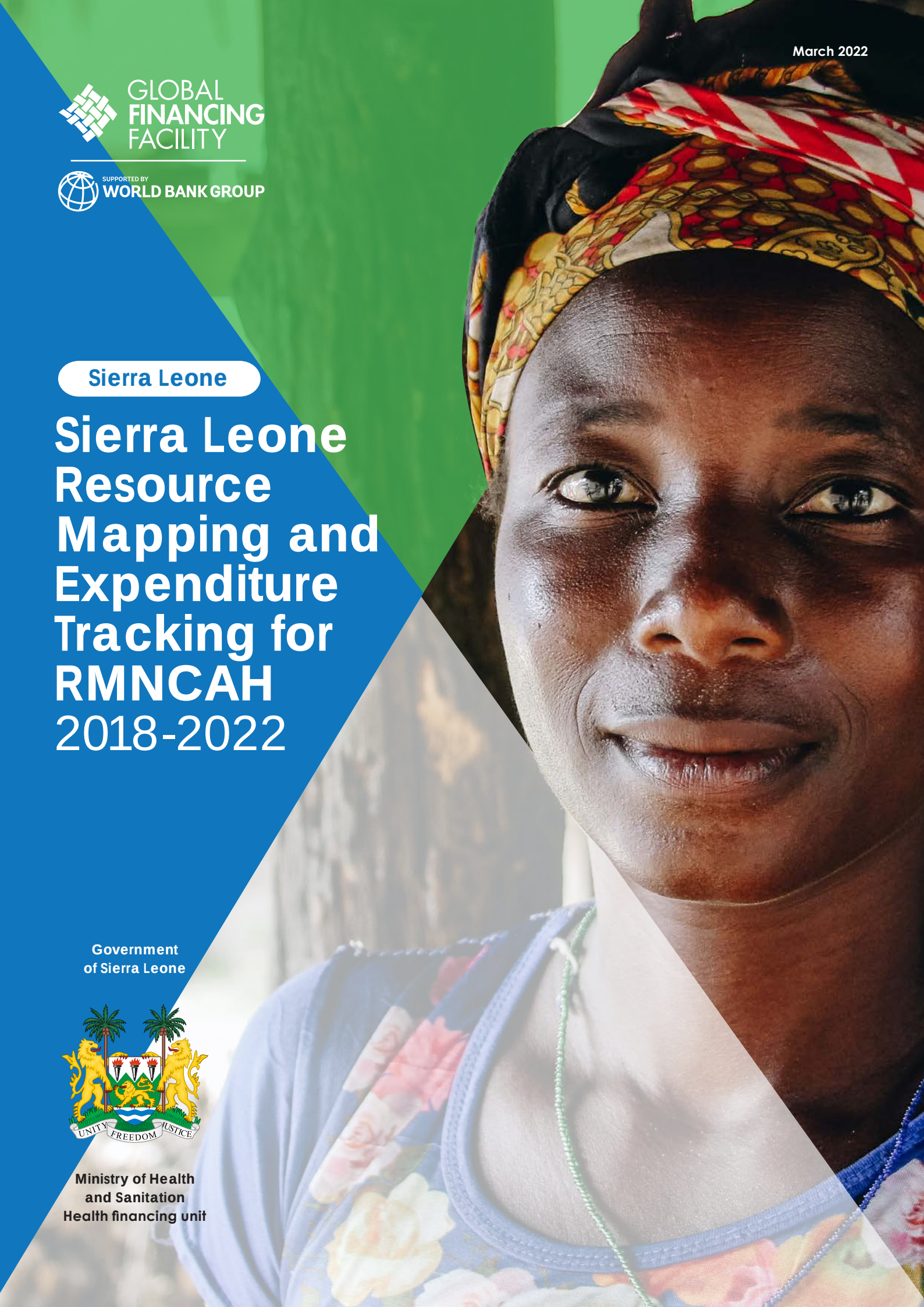

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The vision of the Government of Sierra Leone (GoSL) and Ministry of Health and Sanitation (MoHS) reproductive, maternal, neonatal, child and adolescent health (RMNCAH) Strategy 2017-2021, which is the GFF Investment Case (IC) for Sierra Leone, is to 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 RMNCAH Strategy 2018-2021 (Investment Case) financing gap is large (246m US$), or 48% of the total cost (~450m US$, 2018-2021). While MoH is the largest RMNCAH funder, donors together fund more than MoH. The 2018-2021 gap suggests that financing for the RMNCAH Strategy 2021-2025 will likely show large financing gaps too, and that adequate financing is a key barrier to the provision of RMNCAH services in Sierra Leone.

The RMNCAH Strategy has four strategic objectives (SOs) to guide its main priorities. **The SO with the largest gap it's SO1 – Health system strengthening (HSS, 89m US$, ~40% of the total RMNCAH strategy gap).** Budget, expenditures and gap are all concentrated in SO1 - HSS. Other SOs (SO2 Quality of care, SO3 community health) are more underfunded in percentage, but also have lower budgets in US$. SO4 monitoring, evaluation and research is the only well-funded SO: its financing gap is below 10% of its total cost. Drugs and supplies are largely under-funded vs. other cost categories, while infrastructure and primary health care (PHC) budgets appear very low.

The execution rate of the RMNCAH Strategy budget is 84% in 2020, and therefore show opportunities to improve. MoHS is better at spending its own RMNCAH budget than the health sector general budget, or WB budget. Infrastructure has very low execution, due to MoHS low expenditure in domestic capital. Drugs, and human resources (HR) training are other cost categories that show limited execution.

Given limited financing, allocating budgets to efficient activities and executing budgets completely is even more crucial. These findings suggest that certain areas are particularly underfunded, and therefore that **MoHS and donors budget allocations should be directed** towards those: the PHU and community health system levels, drugs and commodities, and infrastructure.

For both drugs and infrastructure, the RMNCAH Strategy mid-term review (MTR), which surveyed 85 facilities, can provide additional detail on which exact commodities and infrastructural improvements are required. The MTR qualitative findings largely confirmed RMET quantitative findings; in addition, it looked as well into governance and other issues that are beyond the scope of the RMET exercise.

PFM capacity should be improved to facilitate efficient planning and maximize execution. At PHU/district level to ensure donor budgets are executed by MoHS and reach frontlines, and at MoHS central level for managing expenditure and budget planning. In particular, infrastructure, HR training, and drugs budgets show opportunities for improved execution.

There is still a lot we do not know; planned budgets for 2021-2022 for some donors, funding to frontlines, and funding by district are some of the additional data points that would enable even better decision making. Future waves of the RMET exercise should take these into consideration. An immediate next step is to **complete health sector resource mapping** (expected completion date: October 2021), to support MoHS 2022 budget planning phase, and any donor planning currently being undertaken. Other important next steps are to **build health economics capacity in country**, in the short (project-based capacity building) and long term (general country capacity building, i.e. higher education)

I. Introduction and objective

I.1. Introduction

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".

During the RMNCAH Strategy/IC implementation, in 2020, the GoSL and MoHS had also to face the COVID-19 emergency, which required substantial financial, technical, and managerial resources. In addition, 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 RMNCAH Strategy 2017-2021 indeed identified sufficient financing as a significant barrier to achieve the stated vision: a financial gap analysis included in the policy document noted a financial gap of 228m US$ (42% of the total RMNCAH Strategy cost, 545m US$) for the implementation of the strategy.

Given the limited resources and fragmented landscape, a 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 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.

However, both coordination and efficient allocation 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 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 RMNCAH sector.

1.2 Objective

The overarching policy objective of the Sierra Leone RMNCAH RMET is to facilitate coordination across health system financiers, and evidence-based budget decision making. It will do so by answering specific policy questions, as detailed in .

Table 1

RMNCAH RMET policy questions and objectives

POLICY QUESTION	OBJECTIVE; HOW INFORM POLICY (EXAMPLE)	WHEN INFORM POLICY
What is the overall RMNCAH and 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 During donor partners' discussions regarding health funding
Which RMNCAH and 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
What were NHSSP and RMNCAH execution rates of past budget?	Improve execution: expenditure used to review why programs did not spend	During program evaluations
Has COVID-19 impacted RMNCAH budgets?	Improve allocations: ensure that efficient RMNCAH interventions are not substantially de-prioritized	During MoHS budget preparation stage, and anytime budget decisions are taken for donors

II. The RMNCAH 2017-2021 Strategy (GFF Investment Case)

The RMNCAH 2017-2021 Strategy (GFF Investment Case)

The RMNCAH 2017-2021 strategy, which is also the GFF IC for Sierra Leone, is the main policy document guiding the present study. This document has been developed by MoHS with support from donor partners. Its vision is to achieve "zero preventable maternal, newborn, child and adolescents' deaths, well as ensuring each of them live to their full potential".

The RMNCAH Strategy is structured around four strategic objectives (SOs), which have strategies for implementation (Table 2). The RMNCAH Strategy 2017-2021 has been costed at 545m US$.

Table 2

RMNCAH Strategy 2017-2021, Strategic objectives, and strategies

STRATEGIC OBJECTIVE (SO)	STRATEGIES
SO1: Strengthened health systems for effective provision of RMNCAH services	• Adequate skilled and motivated HRH • Strengthened leadership and governance to ensure delivery of RMNCAH services • Availability of essential RMNCAH drugs, equipment and supplies • Infrastructure development in targeted health facilities • Functioning and emergency referral systems • Ensure availability of safe blood at all CEmONC sites
SO2: Improved quality of RMNCAH services at all levels of service delivery	• Develop and support implementation of national RMNCAH quality improvement program • Support implementation of proven systematic procedures, approaches and practices
SO3: Strengthened community systems for effective delivery of RMNCAH services	• Address socio-cultural, geographic and financial barriers to access and utilisation of high impact RMNCAH interventions • Implement iCCM plus as per the CHW scope of practice • Promote implementation of RMNCAH interventions at community level including social accountability • Address other sector determinants to access and utilisation of RMNCAH services
SO4: Enhanced research, monitoring and evaluation for effective delivery of RMNCAH services	• Strengthen national HIS to ensure responsiveness to RMNCAH information needs • Strengthen innovation and use of research to improve delivery of RMNCAH interventions • Strengthen CRVS for delivery of RMNCAH interventions

III. Methodology

The methodology of the SL RMNCAH RMET can be summarized in three stages: preparation, data collection, and data analysis and write-up.

3.1. Preparation

During this phase the scope of the study was agreed. All donors involved in the exercise and various UN agencies (UNFPA, UNICEF, WHO) were involved in the kick-off session and data collection workshop session (both held in February 2021): during both sessions feedback was received regarding the scope of the study and the data collection tool.

After kickoff, the scope was agreed as being top 5 donors only (covering more than 90% of total donor financing, according to National Health Accounts 2018 (forthcoming), national level, from 2018 to 2022, and with details of RMNCAH Strategy objective, sub-objective, and cost category, among others. To assess the possible impact of COVID, all COVID financing was attached to an additional COVID objective. This scope is envisaged to be broadened in the next RMET iteration.

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

3.2. Collection of financial data

For the collection of RMNCAH budget and financial data, the same data collection tool and user guide has been provided to each identified donor partner 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.

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 RMNCAH strategy strategic objective, cost category, health system level, are then produced. Before report writing starts, a validation session with all entities involved in the data collection (MoHS, donor partners, UN agencies) has been carried out to ensure data and analyses are sound. The study report is finally drawn up on the basis of all comments received during the previous phases of the study.

IV. Results

The results section is organized in three sub-sections, which are closely related to the policy questions in section "1.2 Objective". First, the question whether "adequate financing is planned for RMNCAH" will be answered. In this section, under- or over-budgeting by SO, cost category and other categorizations will be discussed. Adequately planned financing that is not executed does not improve health outcomes, therefore the second question would be whether the planned financing is executed. Finally, issues regarding Covid-19 and its impact on RMNCAH will be reviewed.

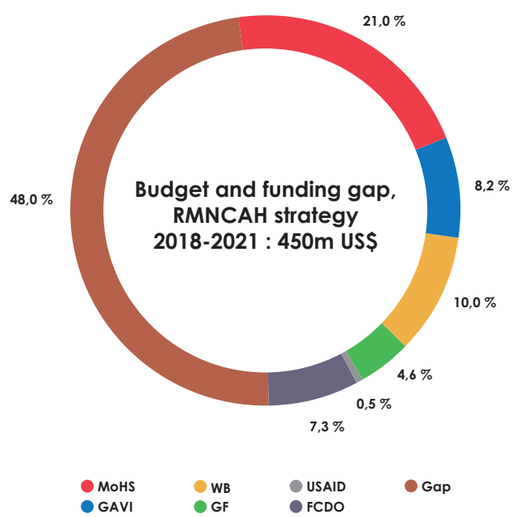
4.1. Budget and gaps: is adequate financing planned?

The total RMNCAH Strategy (Investment Case) budget financing gap is 246m US$ (2018-2021), or 48% of the total RMNCAH Strategy cost (~450m US$, 2018-2021). In other words, the RMNCAH strategy was approximately half financed. The MoHS is the largest RMNCAH financier, and the top 3 donors financiers for RMNCAH are WB, GAVI and FCDO (Figure 1).

Figure 1

RMNCAH Strategy financing gap, across all years and SOs, 2018-2021 period

Source: Author

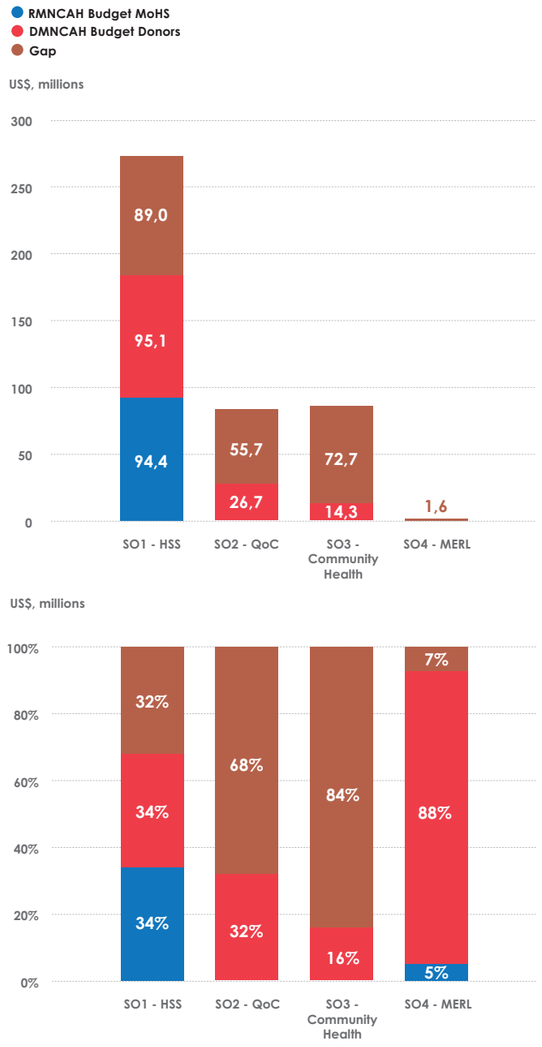


Looking at budget by SO, the largest financing gap in US$ is for SO1 (89m US$, 32% of SO1 budget. However, SO2 and SO3 financing gap is larger in percentage (68% and 84%). SO4 is the only SO that looks adequately financed (financing gap: 7%) (Figure 2).

Figure 2

RMNCAH strategy financing gap, by SO, 2018-2021 period – absolute values and percentages

Source: Author

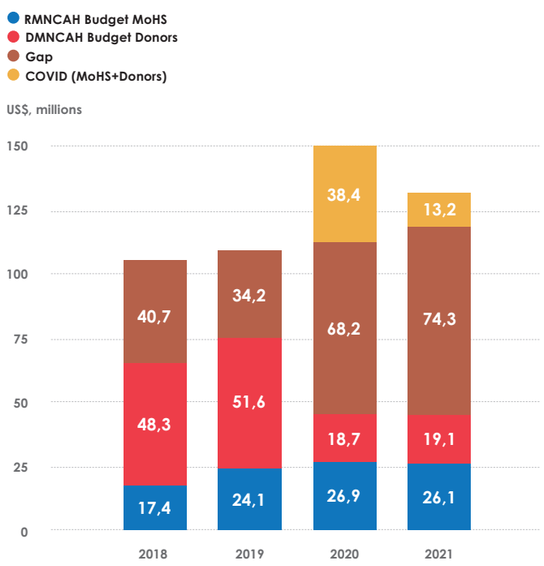


The RMNCAH Strategy financing gap increased in 2020 and 2021, during Covid-19. While MoHS budget grew nominally[1] from 2019 to 2021, there was a large decline in donor partners' RMNCAH budget in the same period. Covid-19 financing correctly appears in 2020: MoHS is the largest overall financier, and WB is the largest financier among donor partners (Figure 3).

Figure 3

RMNCAH strategy financing gap, by year, 2018-2021 period

Source: Author



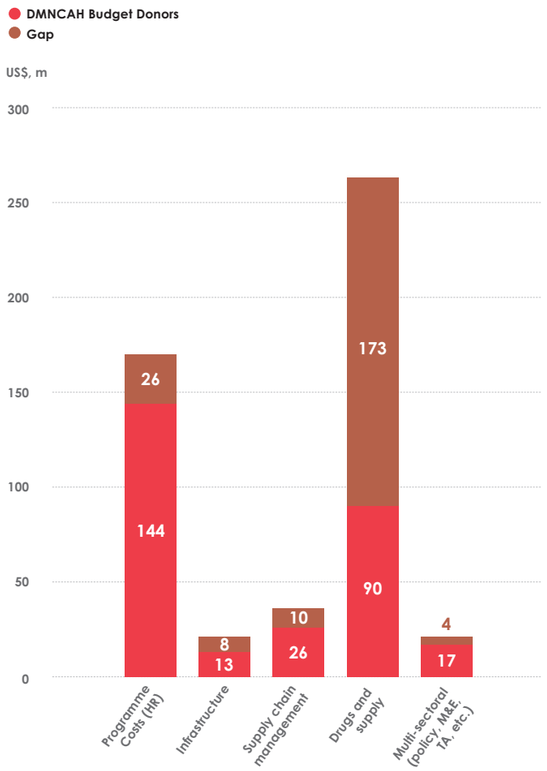
Importantly, the cost category with the largest budget gap is drugs and supplies , while infrastructure budget appears to be particularly low in per capita terms (Figure 4). The RMNCAH mid-term review (MTR) (forthcoming) details the essential medicines and supplies that were the most out-of-stock across 85 facilities: these detailed findings can guide donor partners and MoHS prioritization of essential medicines supplies, plans and budgets in upcoming years.

[1] *The RMNCAH budget grew approximately 8% in the 2019-2021 period. However, in the same period, inflation was approximately +33% and general government expenditure +32%, therefore in real terms the RMNCAH budget actually decreased.*

Figure 4

RMNCAH strategy financing gap, by cost category, 2018-2021 period

Source: Author



Finally, the budget towards peripheral health units (PHUs) and the community level, which deliver primary health care (PHC) services, is below 25% across all study years. While this number may be under-estimated because many activities were mapped to "multiple health system level", this data point suggest that financing towards PHC is rather low.

While this budget gap analysis refers to the 2018-2021 period due to data limitations (i.e., donors budget data for 2022 is very limited, and the RMNCAH Strategy is costed until 2021), there is no reason to believe that in 2022 and future years the budget gap would be smaller. We also note that the findings hold when considering expenditure data instead of budget data.

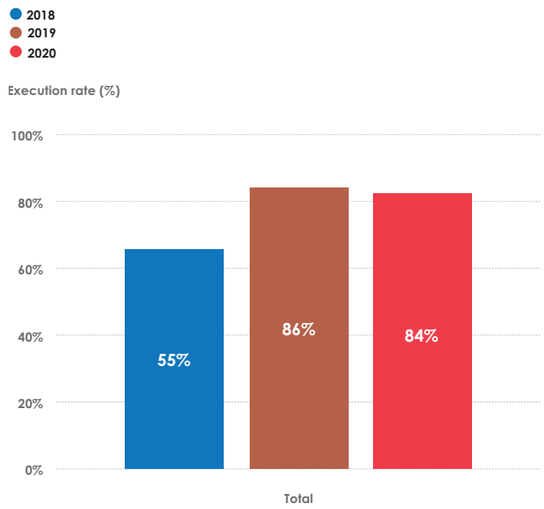
4.2. Expenditure: was the planned budget executed?

Across the full RMNCAH strategy, in 2019 and 2020, execution rates were at 84% and 85% respectively, therefore RMNCAH budgets are largely spent, and show some opportunities for improvement. Execution rates have been improving in the 2018-2020 period, mostly driven by improved World Bank execution rates (Figure 5). It should be noted that for 2020 MoHS expenditure, the figures provided are provisional and not actuals (source: 2021 budget)

Figure 5

RMNCAH strategy budget execution rate, by year, 2018-2020 period

Source: Author

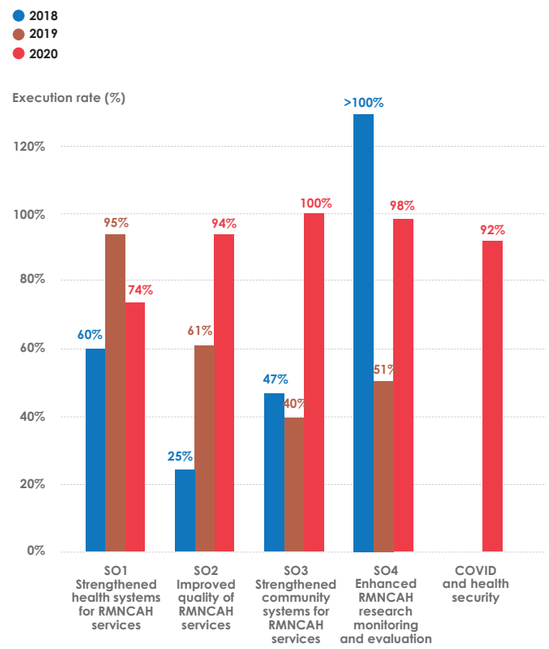


Major differences in execution rates are by year, rather than by SO: across all SOs except SO1 budget execution rates improved in the study period (Figure 6), and the decline in SO1 2020 execution is due to capital expenditure budgets that were not executed by MoHS.

Figure 6

RMNCAH strategy budget execution rate, by SO and by year, 2018-2020 period

Source: Author

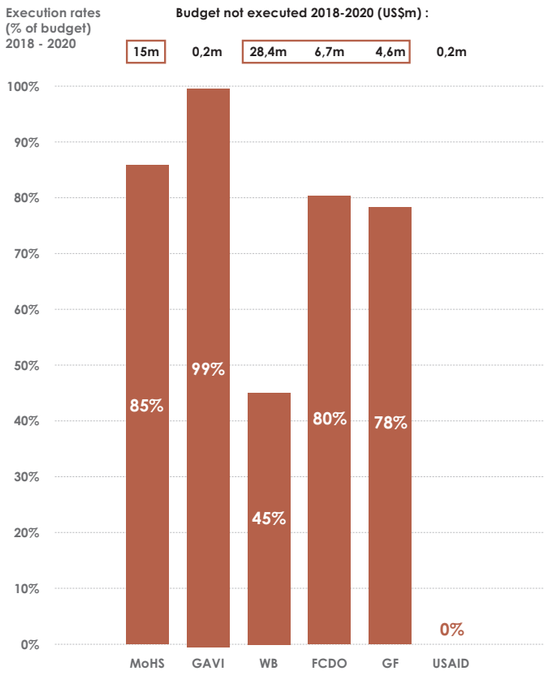


Execution rates by donor show that GAVI completely spent their budget, most donors and MoHS had execution rates ~80%, and the donor with the most sizable opportunity for improvement is the World Bank (Figure 7). However, World Bank execution rate in 2020 significantly improved vs. previous years (execution rate for World Bank in 2020: 76%), suggesting a positive trend. It should be noted that the main implementer for World Bank funding is the MoHS.

Figure 7

Execution rates by donor, 2018-2020 period, and amount of budget not executed (top of graph)

Source: Author



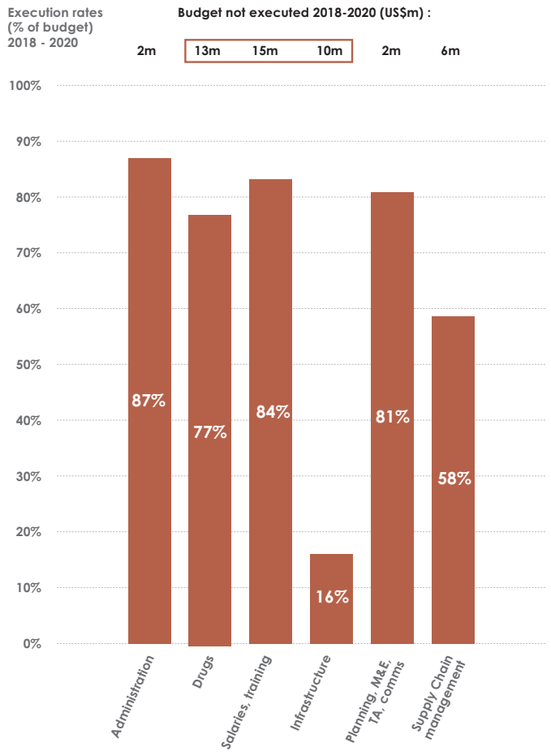
Turning to execution rates by cost category, infrastructure is clearly the cost category which shows the largest opportunity for execution improvements; this is driven by MoHS capital expenditure projects. Except for supply chain management (58% execution rate), other cost categories execution rates are between 77% and 87% (Figure 8). In the HR category, salaries budgets are largely executed, while the same is not true for training budget.

It should be noted that RMNCAH MTR, which surveyed 85 facilities across all health system levels, identified and detailed specific equipment and infrastructure needs, at facility level: these detailed findings can be useful when planning for equipment and infrastructure upgrades.

Figure 8

RMNCAH strategy financing gap, by cost category, 2018-2021 period

Source: Author



In summary, across the full RMNCAH strategy, RMNCAH budgets are largely spent, and execution rates have been improving in 2019 and 2020. There are opportunities for improvement: to push budget execution from the current 85% to 95% or more, execution must be improved for infrastructure, and in second instance for drugs, and trainings.

4.3. RMNCAH and Covid-19 financing

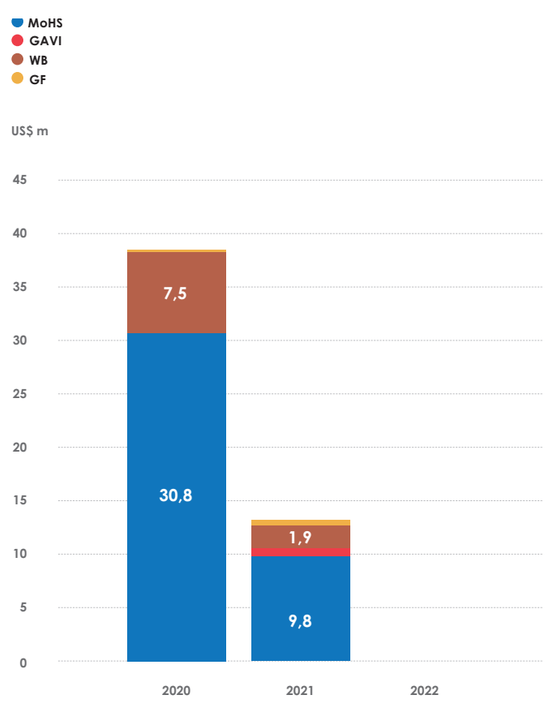
In this section we will detail who is funding the Covid-19 response in Sierra Leone, whether Covid-19 financing appear to be "staying" in future years, and whether Covid-19 financing was incremental to or had an impact on RMNCAH financing.

First, the Covid-19 response has been largely financed by the MoHS, and to a good extent by the World Bank. While Covid-19 World Bank financing is not available for 2022, there is no GoSL Covid-19 (i.e., National Covid-19 Emergency Response Centre, NaCOVERC) budget allocation for 2022 (Figure 9).

Figure 9

Covid-19 financing, by year and by source of funding, 2020-2022 period

Source: Author

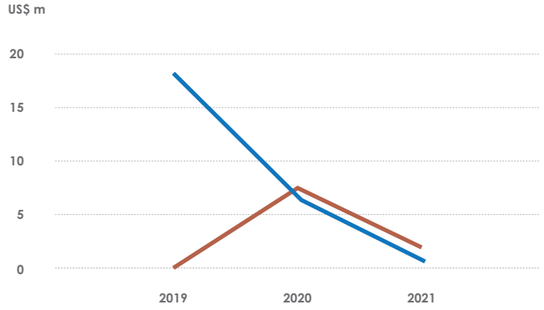


Finally, it appears that Covid-19 budget has been reallocated from RMNCAH budget. For WB, it appears that Covid-19 financing has largely substituted RMNCAH funding in 2020 (Figure 10). For MoHS, Figure 2 shows that 2020 Covid-19 budgets were largely incremental, while the same is not true in 2021. The share of budget dedicated to the health sector remained stable at 11% in 2020 and 2021, as GoSL budget grew by 13%. However, in 2021, GoSL RMNCAH budget decreased -3%, implying that Covid-19 health sector financing in 2021 was to a certain extent funded by reallocations internal to the health sector.

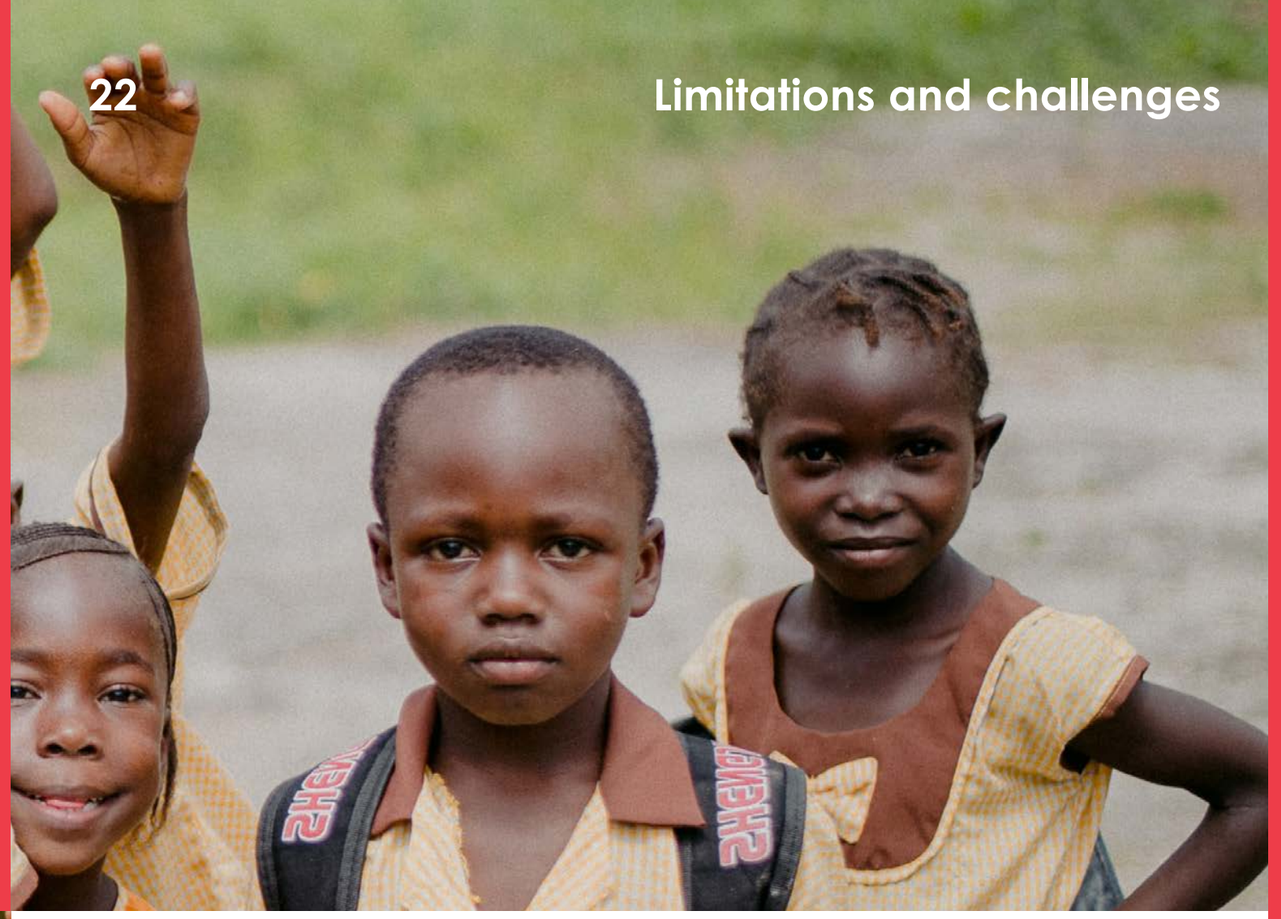
Figure 10

World Bank Covid-19 and RMNCAH financing

Source: Author



V. Limitations and challenges



This is the first time this exercise is done since approximately five years and it will hopefully be continued further. It is therefore important to understand opportunities for improvement:

- **Data by district was not collected:** the decision was taken as this is the first RMET exercise in a long time. Data by district in the future could however inform geographic resource allocation formulas.
- **Data by health system level, especially PHC and frontline workers, was largely not available:** although we attempted to collect it, it was not possible to break down expenditure by primary, secondary and tertiary healthcare in the vast majority of cases. Data was mapped to "multiple health systems levels".
- **Data for 2021-2022 was not available for (most) donors, and only top donors were included in the exercise.** The value of the exercise is severely diminished by the lack of visibility of donor budget for years 2021-2022. Hopefully donors will be able to share planned-not-yet-approved budget next year. It should also be noted that only top donors were included, so not all donors data is included in the analysis, and one donor has not provided full data (see section 3.2).
- **There is a bias towards large cost categories and program areas.** Investments are not budgeted or tracked based on MoHS RMNCAH 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
- It should be noted **2020 MoHS expenditure data is provisional and not actual** (source: 2021 budget), therefore the execution rate for 2020 using actual expenditure may differ from the execution rate noted in this document

VI. Conclusions

Conclusions

The total RMNCAH Strategy 2018-2021 (Investment Case) financing gap is large (246m US$), or 52% of the total cost (~450m US$, 2018-2021). While MoH is the largest RMNCAH funder, donors together fund more than MoH. The 2018-2021 gap suggests that **RMNCAH Strategy 2021-2025 will likely have a large gap too**

The SO with the largest gap it's SO1 – Health system strengthening (89m US$, ~40% of the total RMNCAH strategy gap). Budget, expenditures and gap are all concentrated in SO1 (HSS). Other SO (SO2 Quality of care, SO3 community health, and SO4 M&E/research) are more underfunded in percentage, but also have lower budgets in US$. Drugs and supply chain management are largely under-funded vs. other cost categories.

Execution are at 84% in 2020, and therefore show opportunities to improve. MoH is better at spending its own RMNCAH budget than the health sector general budget or WB budget. Infrastructure has very low execution, due to MoHS low investment execution. Drugs, and HR training are other cost categories that show limited execution.

Given limited financing, **allocating budgets to most efficient levels (i.e., PHUs) and executing budget completely is even more crucial.** The implications of the above findings are:

- **Increase MoHS and donors budget allocations** towards:
  - PHU and RMNCAH services, known for being highly cost-effective, and having high execution
  - Drugs and commodities
  - Infrastructure

For both drugs and commodities, and infrastructure, the RMNCAH MTR, which surveyed 85 facilities across Sierra Leone, can provide additional detail on which exact commodities and infrastructural improvements are required. It should also be noted that qualitative findings from the MTR confirm the quantitative findings from the RMET, and also reviewed additional topics such as health governance.

- **PFM capacity should be strengthened to improve planning and maximize budget execution:**
  - At PHU/district level to ensure donor budgets are executed by MoHS and reach frontlines. [Comment: can we reference here the Fiduciary assessment report by WB and MoHS? I do not think it is or will be public.]
  - At MoHS/MoF central level for managing expenditure and budget planning. In particular, infrastructure, training and drugs budget show opportunities for improved execution
- **There's still a lot we do not know** (planned future budgets for some donors, funding to frontline, funding by district) that would enable even better decision making. **An immediate next step is to complete health sector resource mapping** (expected completion date: October 2021), to support MoHS 2022 budget planning phase, and any donor planning
- Another related next step is to **build health economics capacity in country**, in the short (project-based) and long term (general country capacity)

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Ministry of Health and Sanitation
Health financing unit

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