Oxford Policy Management

Sierra Leone
Free Health Care Initiative

Findings of independent evaluation team

April 2016

Contents

Background

Introduced by the President of Sierra Leone in 2010, the FHCI abolished health user fees for pregnant women, lactating mothers and children under five years of age.

- Very high mortality and morbidity levels among mothers and children in Sierra Leone – some of the worst in the world;
- Reports that financial costs were a major barrier to health service uptake and use by these groups.

The FHCI is:

- **Drugs and equipment:** The continuous availability of equipment, drugs, and other essential commodities;
- **Health workforce:** Adequate number of qualified health workers;
- **Governance:** Strengthened and effective oversight and management arrangements;
- **Infrastructure:** Adequate infrastructure to deliver services;
- **Communication with the general public:** More and better information, education and communication to stimulate demand for free quality health services;
- **Monitoring and evaluation (M&E):** A comprehensive M&E system;
- **Financing:** Sufficient funds to fund the FHCI.

Methods

- Covers the period 2010 to 2015 (but primarily focussed pre-Ebola)
- Assesses the extent to which:
  - the FHCI has contributed to saving lives through improved health outcomes for the target groups
  - the initiative represents value for money (VfM)
- Responds to questions on how effectively the FHCI was implemented, whether it addressed the right interventions, whether other barriers still remained, equity effects, unintended consequences and how to sustain the FHCI in the future
- Theory-based evaluation approach, using contribution analysis
- Limitations:
  - No baseline or control group
  - Intervention dynamic over time
  - Weak data systems and data systems affected by intervention
  - Models incorporate some assumptions (e.g. LiST)

Evaluation approach

Theory of change

Data tools and analysis

- time series analysis for the contribution of the FHCI to observed trends (DHS)
- modelling of impact using the Lives Saved Tool (LiST)
- modelling of future revenues and expenditures for the fiscal space analysis
- 137 KIIs at national and district level, 48 focus group discussions
- extensive document review
- analysis of routine information systems (HRH, drugs etc.) and periodic reviews (NHA, HFAC data, one-off studies)
- regression analysis conducted by ReBUILD

Distribution of FGDs by participant category, district and region

Region	District	Young people (18–24yrs)	Adult females (25+yrs)	Adult male (25+yrs)	Community leaders	Total
West	Western Area	3	3	3	3	12
East	Kono	3	3	3	3	12
North	Koinadugu	3	3	3	3	12
South	Bo	3	3	3	3	12
Total FGDs		12	12	12	12	48
Total participants		90	85	87	89	351

1. Are the seven priority interventions the right ones to ensure continued and increased utilisation of services by the target beneficiaries?

- Each of the pillars was relevant and appropriate – even essential – to making the FHCI potentially effective
- Distinguishing features of the FHCI => systematic approach adopted
- Quality of care (cross-cutting) neglected
  - E.g. improving staff performance and responsiveness
  - clinical supervision in support of evidence-based practice
  - monitoring of core quality of care indicators
- Limited community engagement

2. How and to what extent were the seven priority interventions that were put in place effective in enabling the FHCI to be operationalised?

FHCI was systemic change: strength but also source of risk

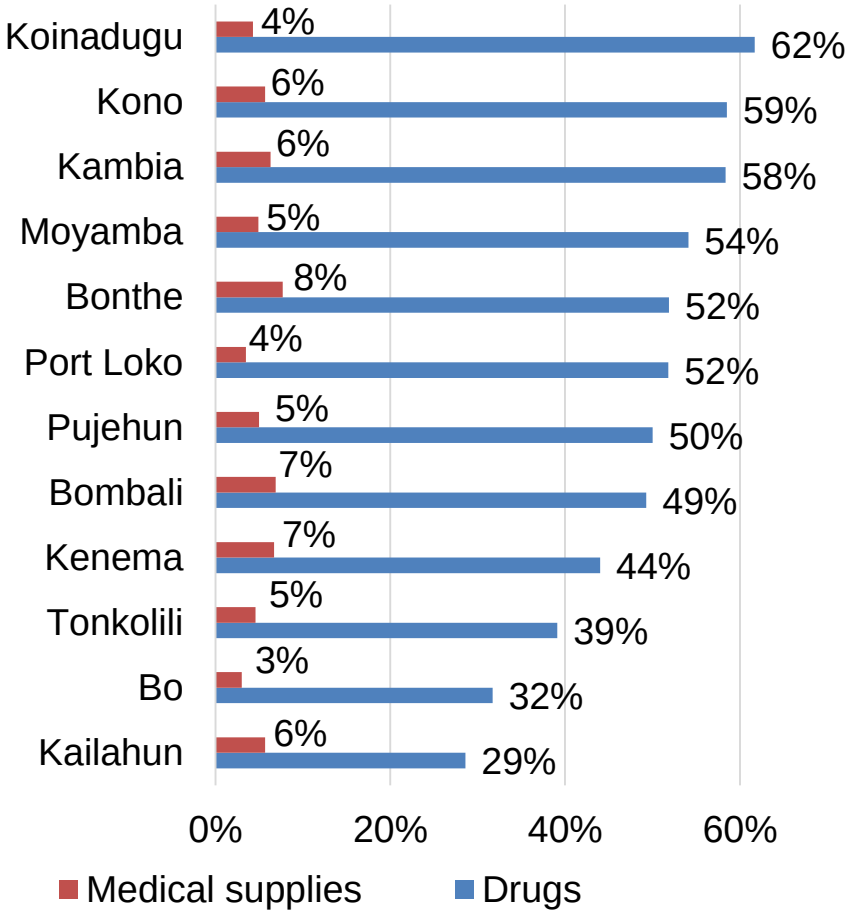
Some real gains :

- revitalising structures for sector governance (TWGs, JPWF, NHSSP and Health COMPACT, for example)
- increased staffing
- better systems for staff management and pay
- also for getting funds to the facilities
- new M&E systems introduced and facility audits conducted
- infrastructure improved from very weak starting point
  - FIT assessment reports show linear progress in 2010 to 2013, with the proportion of sampled public facilities able to deliver BEmONC rising from 47% in November 2010 to 82% in July 2013, and from 63% to 89% in the same time period for CEmONC services
- communication campaign initiated and high population awareness (though not always detailed)
- underlying these measures was an increase in health financing resources, including a prioritisation of MCH programmes and a switch from household to donor spending to some degree

But challenges and loss of momentum too

- improvements to pharmaceutical procurement and distribution were not effective
- in other areas reforming momentum was lost ove time
- we see problems that we tackled just prior to the FHCI, like cleaning the payroll, re-emerging as problems now

Proportion of facilities experiencing stock-outs by district, 2012



Source: HFAC (2012). Number of facilities: 274

3. What are the socio-cultural issues that affect the uptake of free health care among the target beneficiaries?

- Studies undertaken since 2013 highlight that health care seeking in Sierra Leone is a socially negotiated process where factors such as cultural norms, beliefs about disease, acceptability of interventions, perceptions on quality of care, household power relations and social networks are all very influential.
- We examined five barriers to health care utilisation and health gain (the 5 ‘A’s): affordability, access, awareness (of the policy and danger signs for mothers and children), attitudes (toward health seeking) and accountability.
  - All show improvements over the period, though some are modest.
    - Awareness of the policy is high among all population groups
    - Evidence that the FHCI contributed to:
      - increased awareness of danger signs by the community
      - greater willingness to seek health care for children
      - to a small extent, greater accountability on the part of services

  However, all of these barriers need continued focus and improvement as the health system moves ahead

4. What contributions to health outcomes, among the target groups, did the FHCI make? Mortality

The picture on changes in mortality following the introduction of the FHCI is mixed. This is partly due to the difficulty in measuring maternal mortality in the absence of a robust vital registration system.

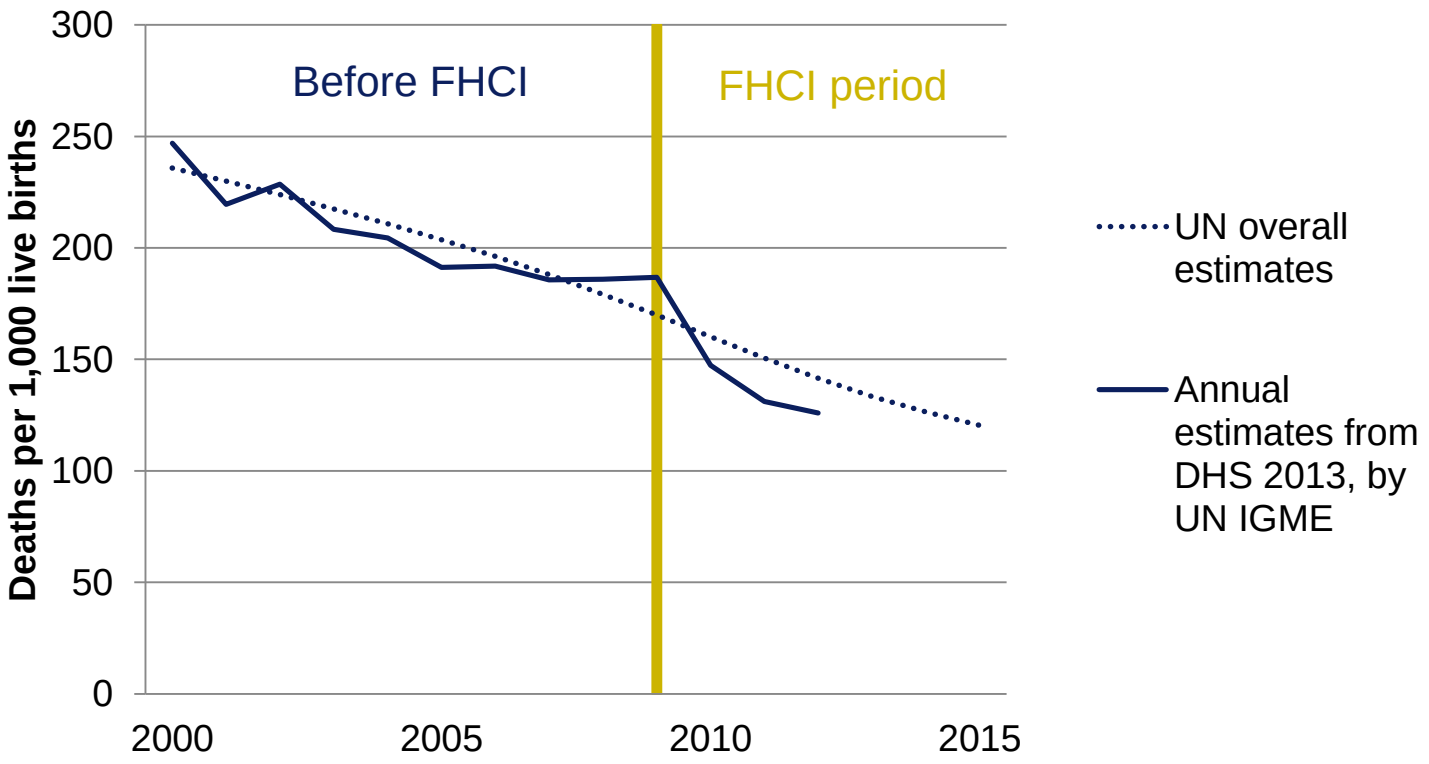
MMR:

- latest UN estimates of maternal mortality put the levels in Sierra Leone at the highest in the world
- Central estimates do show declining levels but these are accompanied by wide uncertainly intervals that make it difficult to draw firm conclusions on the trend
- **Not possible to measure directly if maternal mortality has changed as a result of the FHCI**

Child mortality – clearer trends and contribution of FHCI

- The UN-modelled estimates show a **declining trend**
- The UN has also produced annual estimates of under-five mortality using the 2013 Demographic and Health Survey (DHS). **These show a sharp reduction in rates immediately after the start of FHCI.**
  - The levels fell from 187 deaths per 1,000 live births in 2009 to 147 in 2010. The level continued to fall in the following years, reaching 126 per 1,000 live births in 2012. The bulk of this fall relates to children aged between one month and five years
- The fall in neonatal mortality (deaths under the age of one month) has been slower

Under five mortality rate



Source: The UN Inter-Agency Group on Child Mortality Estimation (IGME)

Summary on health gains

The overall conclusion that we can draw from our review is that the FHCI is **likely to have contributed to the gains in under-five mortality reduction, increased coverage of MCH services and equity of MCH service coverage, which were significant in absolute terms**.

The gains are clear but the attribution is less so as:

- the 2008 DHS was the first of its kind, making it hard to assess whether the improvements in coverage accelerated after 2010 compared with earlier growth
- Ebola has clearly had a major impact on health outcomes, although this is masked in our evaluation by the fact that the main data sources analysed for health outcomes predate Ebola, unlike the qualitative tools that capture part of the Ebola and post-Ebola story.
- Social determinants of health are an important part of the picture too, although in general they have improved slowly over the period and so are not likely to be major explanatory factors behind any health improvements seen
- External investments have played a part, especially support to infrastructure and the major disease programmes such as malaria and vaccination
- There have been some improvements in poverty rates and the overall economy, albeit subject to recent shocks

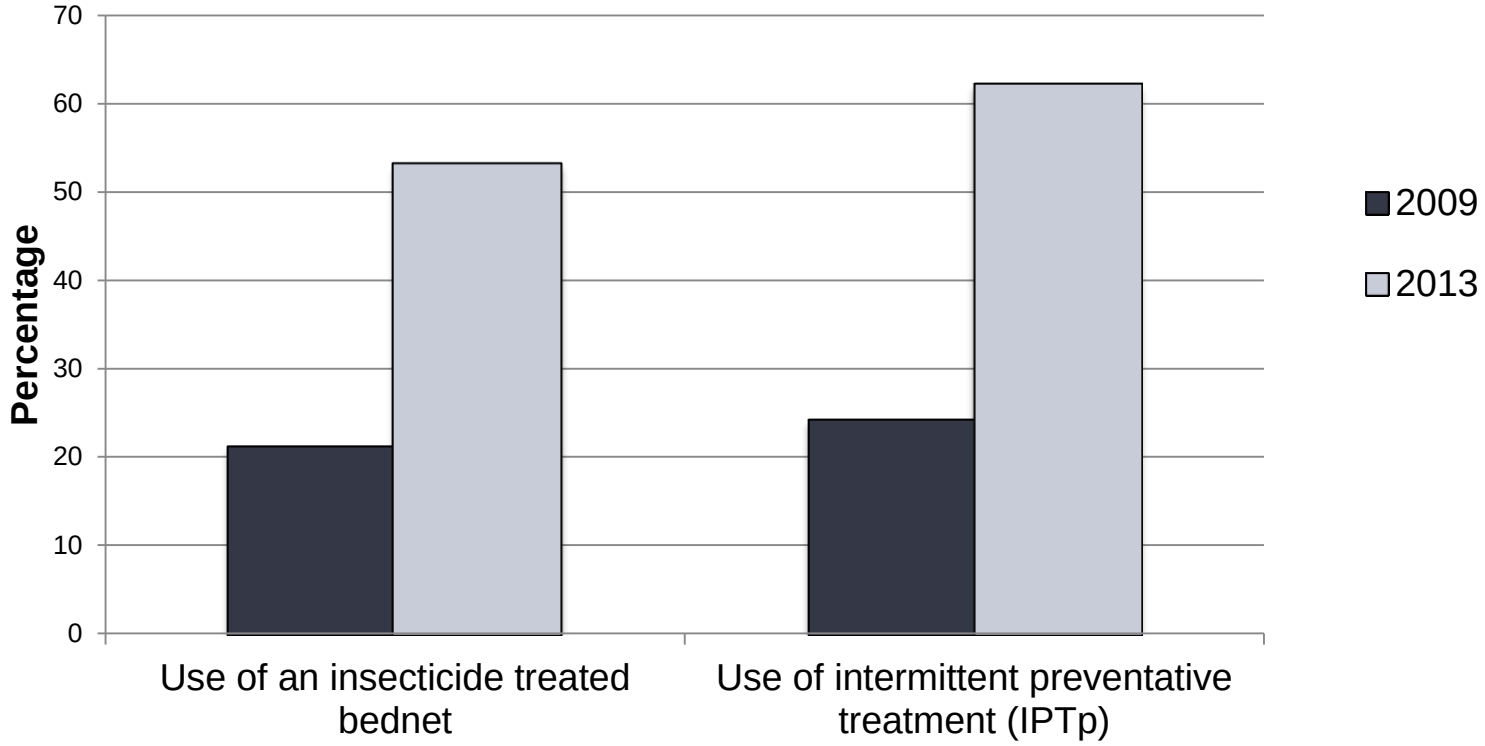
Contributions to health outcomes, among the target groups – morbidity and coverage

- **Prevalence: acute respiratory infection (ARI), fever and diarrhoea** for children under the age of five years.
  - little change in the prevalence of these symptoms in under-fives comparing before and after the FHCI, despite an increase in interventions that should have improved these, such as reported bed-net use.
  - the nutrition indicators for these children did show large improvements, with the proportion of underweight children falling sharply.
- **Clear improvements in the coverage and uptake of services** in recent years. Some of these appear to have started before the launch of the FHCI, but there have also been positive changes after the start of the initiative.

Contributions to health outcomes, among the target groups – coverage of essential services for mothers and newborns

- **Basic antenatal care (ANC) is now near universal** in Sierra Leone, reaching 98% in 2010/11, up from 88% in 2004-9; however, the improvement in overall coverage appears to have been predominantly before the FHCI.
- **Births in a health facility remain low** by international standards but there have been improvements.
  - started before the FHCI but growth in the numbers since 2010, from 36% in 2004-9 to 57% of all births in the period 2010 to 2013.
  - the picture is similar for births that are attended by a skilled health worker, with improvements both before and after FHCI.
- **Coverage of postnatal care (PNC) improved** since the start of the FHCI, with the HMIS data in particular showing strong growth:
  - numbers of first PNC appointments rose by 50% between 2010 and 2014.
  - DHS showed coverage up from 60% in 2009 to 73% in 2013.This suggests that the quantity of PNC has increased as a result of the FHCI.

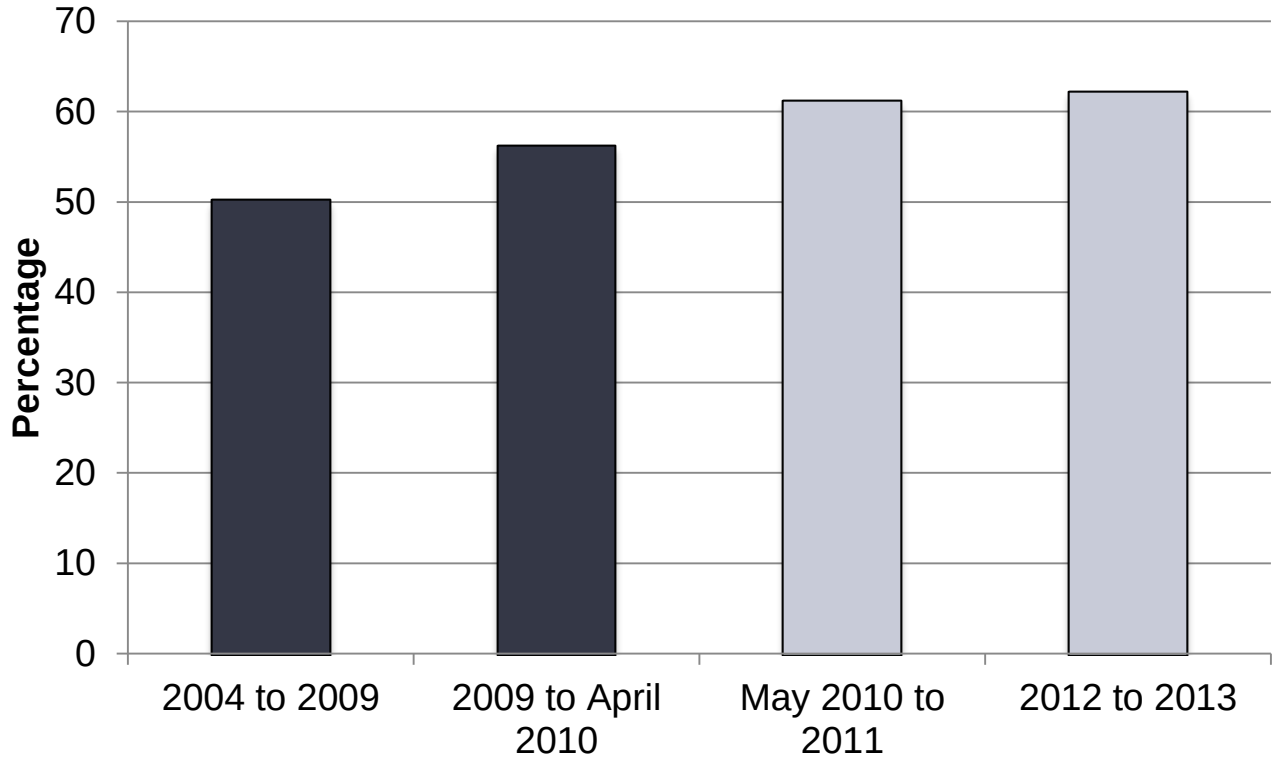
Malaria prevention in pregnancy



Sources: DHSBS 2009 and DHS 2013

Large improvements in malaria prevention during pregnancy. The use of both ITNs and IPTp more than doubled between 2009 and 2013

Delivery assisted by a skilled health worker

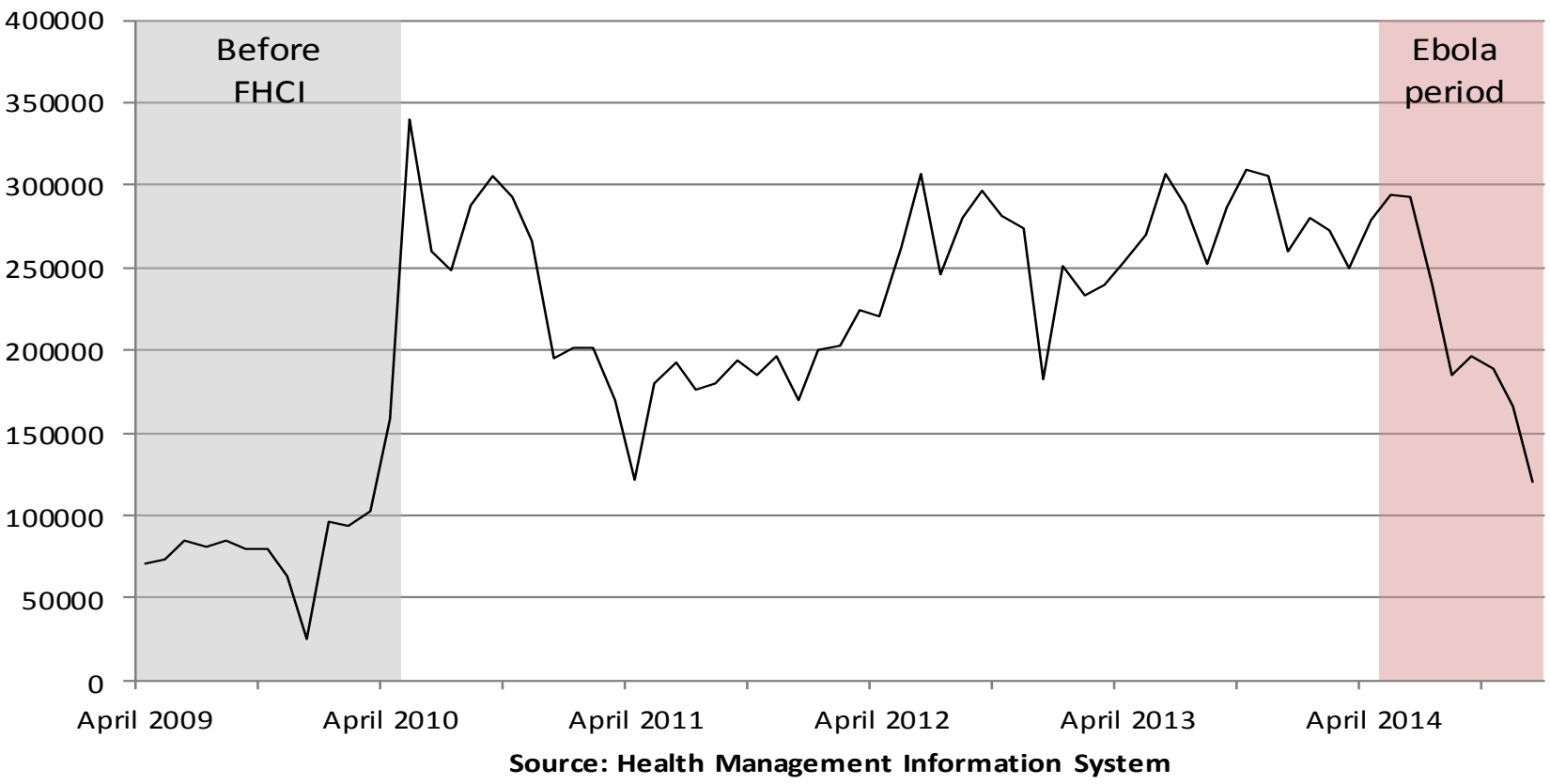


Sources: 2008 and 2013 DHS

Births assisted by a skilled health worker have increased both before and after the start of FHCI. (Although the increase seen before April 2010 may be due to data quality weaknesses in the 2008 DHS)

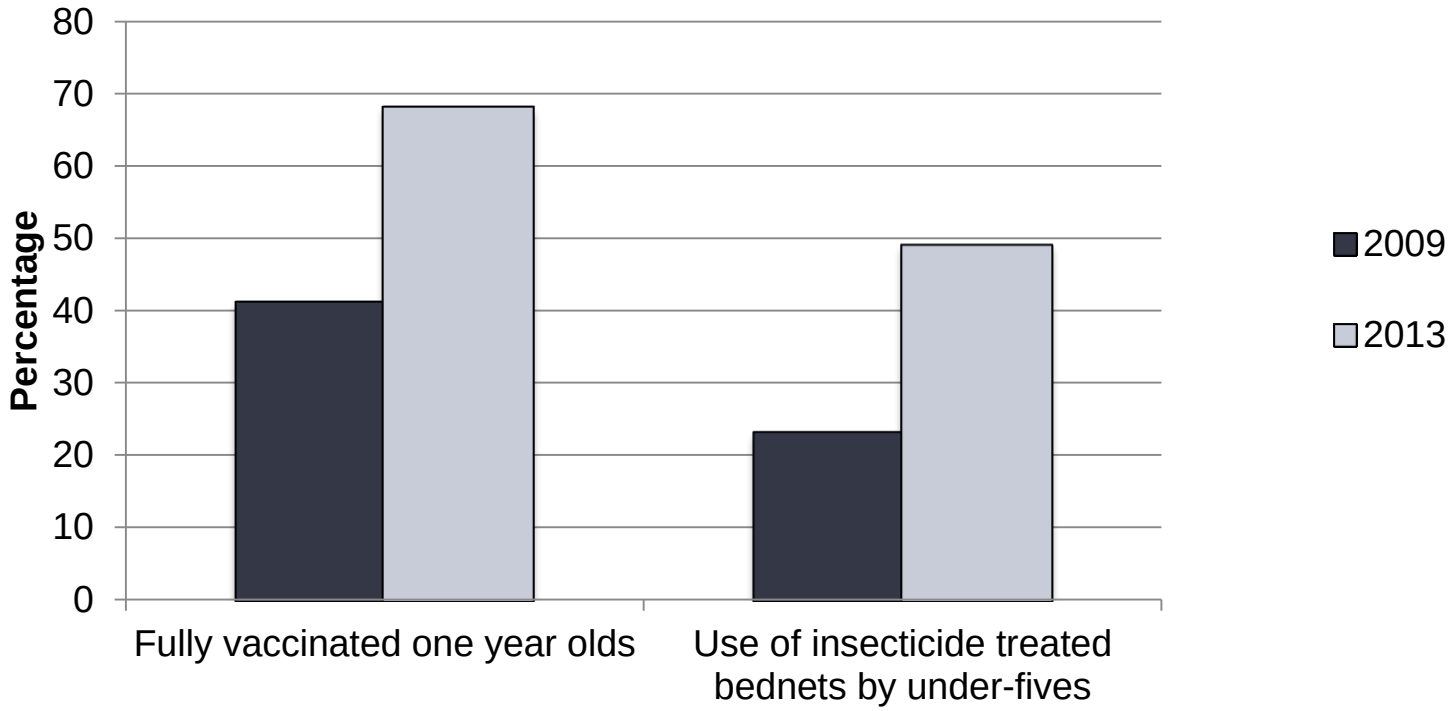
Contributions to health outcomes, among the target groups – coverage of essential services for under-fives

Number of consultations for under-fives per month



Source: Health Management Information System

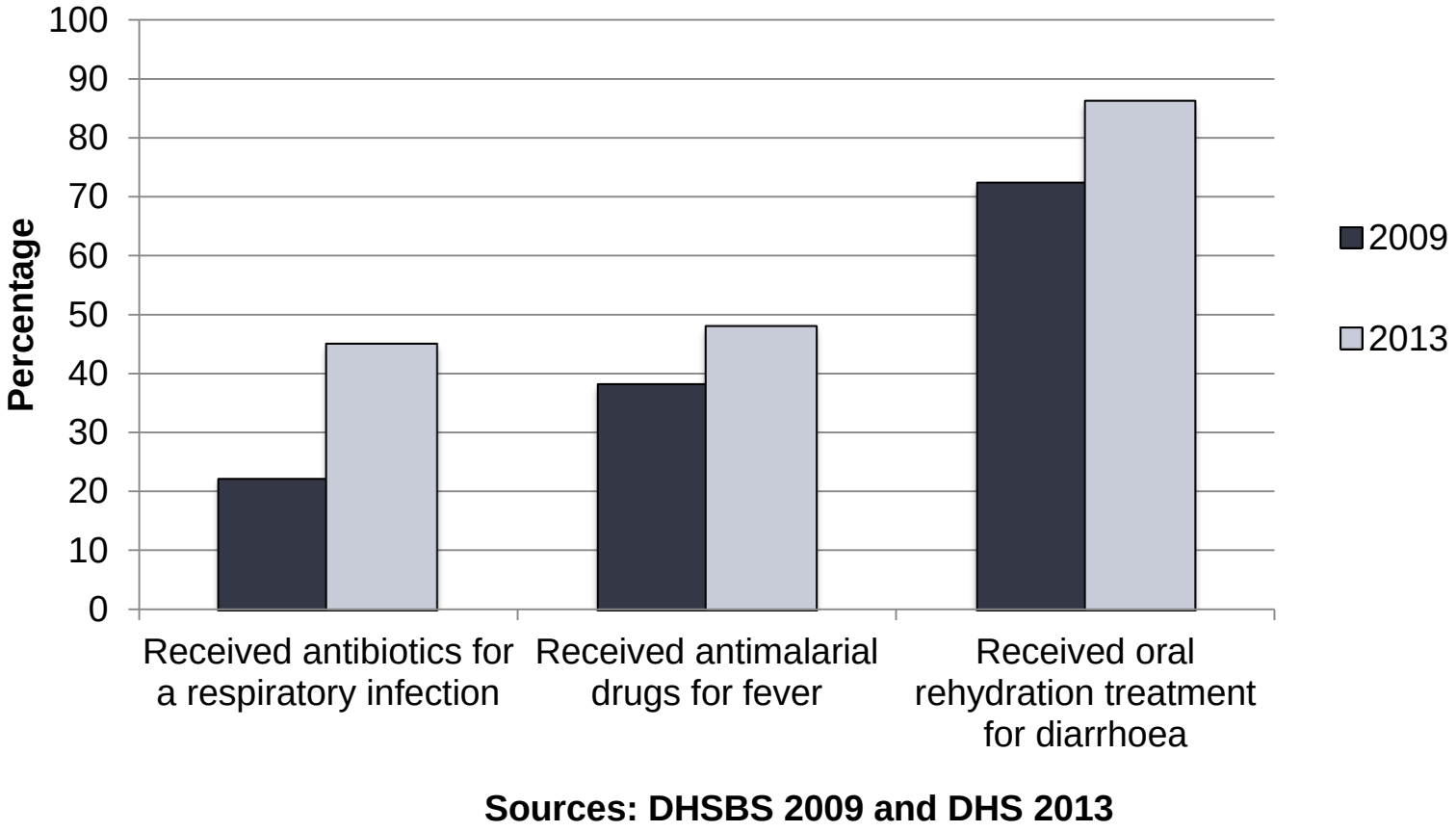
Disease prevention for under-fives



Sources: DHSBS 2009 and DHS 2013

Large improvement in disease prevention for children between 2009 and 2013

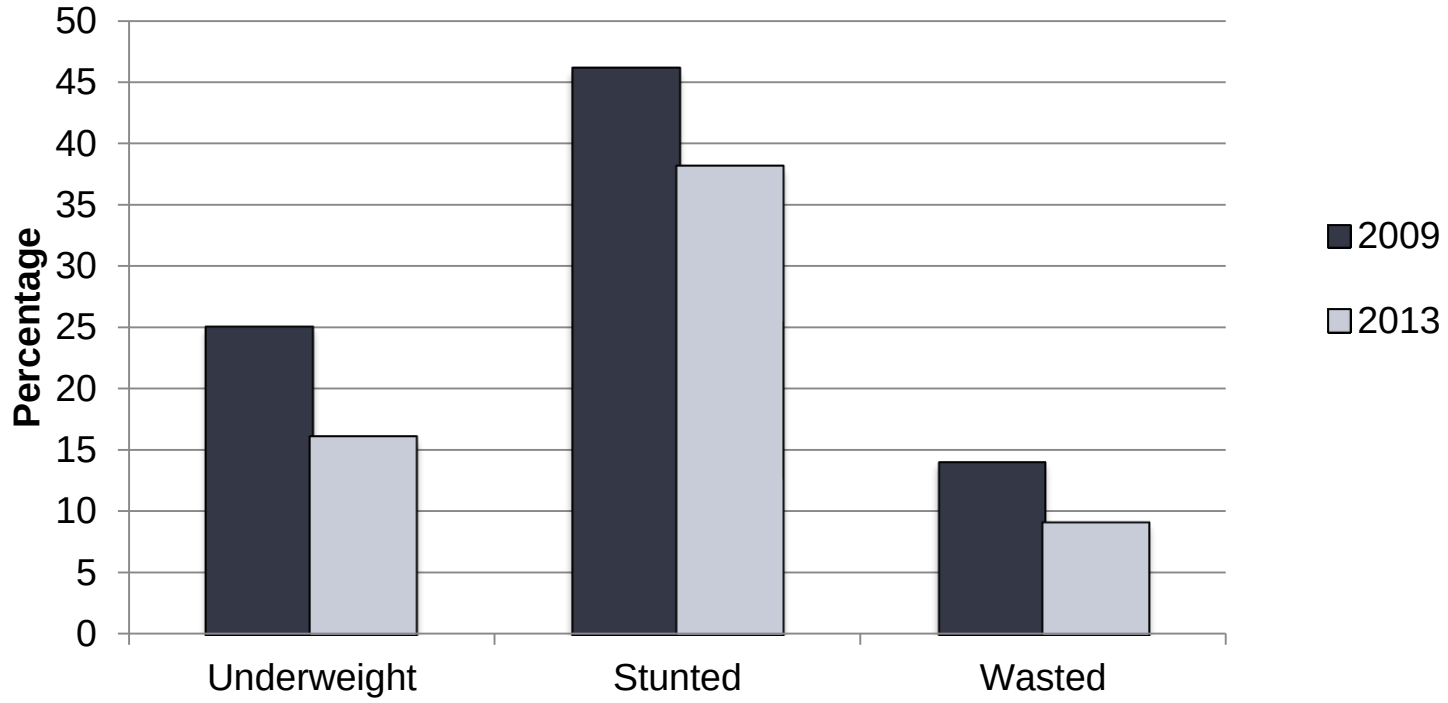
Treatment rates of under-fives



Sources: DHSBS 2009 and DHS 2013

Improvements in treatment rates for under-fives between 2009 and 2013

Nutrition indicators for under-fives



Sources: DHSBS 2009 and DHS 2013

Improvement in under-five nutrition indicators between 2009 and 2013

How were these achieved?

HSS noted earlier. But: the improvements in the health system will only be effective if they result in reduced barriers for users, particularly increased affordability of services and increased acceptability and quality of care.

Affordability:

- there is evidence at the macro level of a **shift in funding from households to donors**
  - Household funding as a proportion of total health expenditure has gone from a high of 83% in 2007 to 62% in 2013, with donor funding ranging from a low of 12% in 2007 to a high of 32% in 2013
- **absolute expenditure remains low per capita** and households are still the predominant source of health care finance
- data from various sources suggest that chance of **payment and amount of payment has reduced for FHCI groups**, although evidence also consistently shows that a minority of those in FHCI groups are still paying for health care (12% in a recent studies)

Quality of care is not only affected by the FHCI and its implementation but is also a determinant of its success.

- **challenges** to quality of care in the delivery of MCH services **continue to be wide-ranging**, with both supply- and demand-side factors as well as underlying social determinants exerting influence.
- Some progress from a weak base had been made prior to the Ebola outbreak, largely catalysed by the FHCI but also by other programmes focusing on reproductive, maternal, neonatal and child health (RMNCH), according to documentary evidence and KIIs, but the health services remain weak. In addition, **the evidence base to track changes to care-giving in facilities is exceptionally weak**.
- Information from before the FHCI on user satisfaction is not available. Patient satisfaction was generally higher for care received at lower-level facilities (MCH posts, compared to health centres). **Our FGDs highlight concerns about the state of the health care infrastructure, staffing levels, skills and attitudes, and the non-availability of drugs in particular**.

5. Did the FHCI have a differential impact on different socioeconomic groups or marginalised groups?

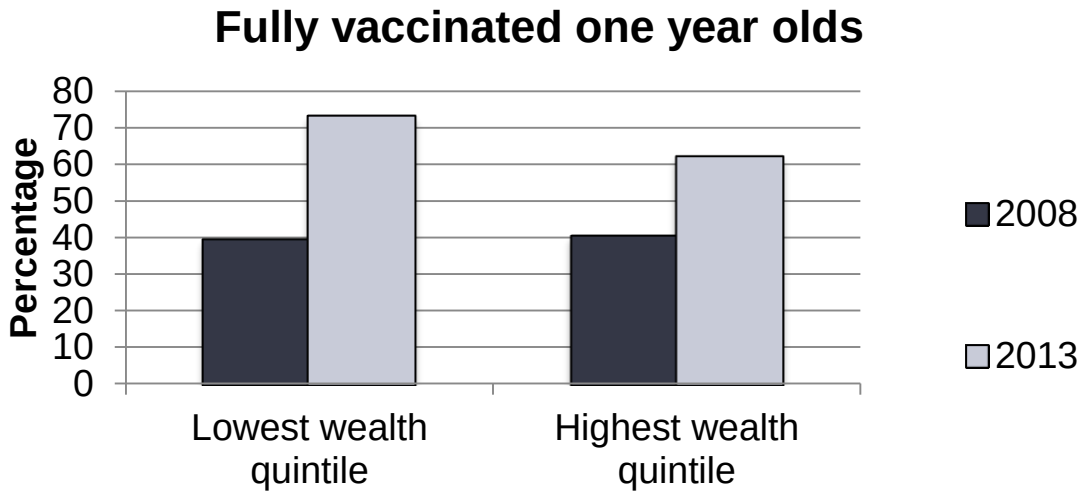
The evidence for changes to the gaps in coverage between socioeconomic groups from DHS data is encouraging for the period 2008 to 2013.

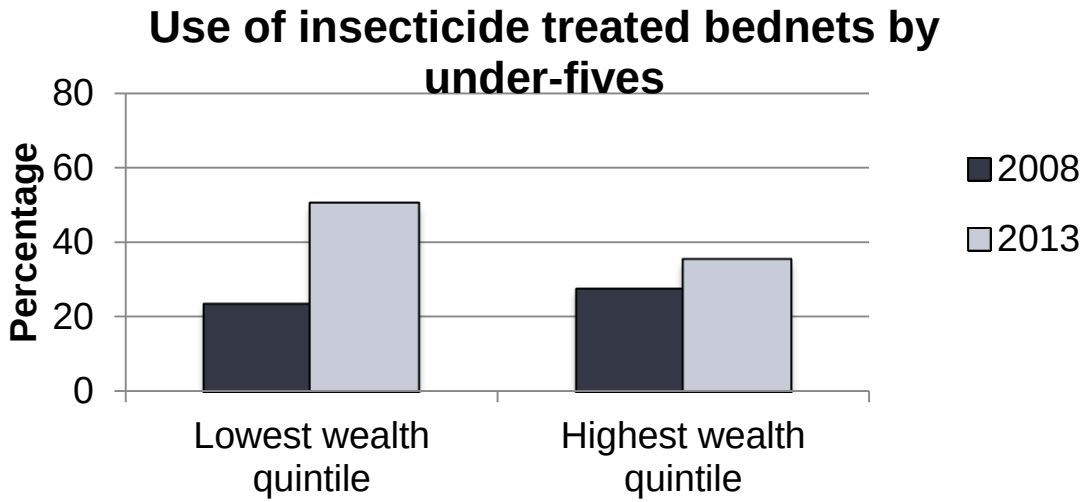
- inequalities reduced for almost all indicators
- for some coverage is now either equal or even positively pro-poor (such as use of treated bed-nets for pregnant women, and childhood immunisation)
- gap between geographical areas and wealth groups has narrowed for PNC
- growth in use of ITNs for under-fives was particularly noticeable among those in rural areas and the bottom four wealth quintiles
- lowest wealth quintile group for child immunisation has seen the most improvements: before the FHCI rates were fairly even across groups but the latest figures show the bottom wealth quintile now has higher rates than others

Skilled attendance at delivery and facility deliveries remain a challenging area, as is the case in many low-resource settings globally

- it is plausible that the FHCI has been a significant contributory factor to increasing facility deliveries at a faster rate for the lower wealth quintiles, although significant differences in coverage still remain in absolute terms.

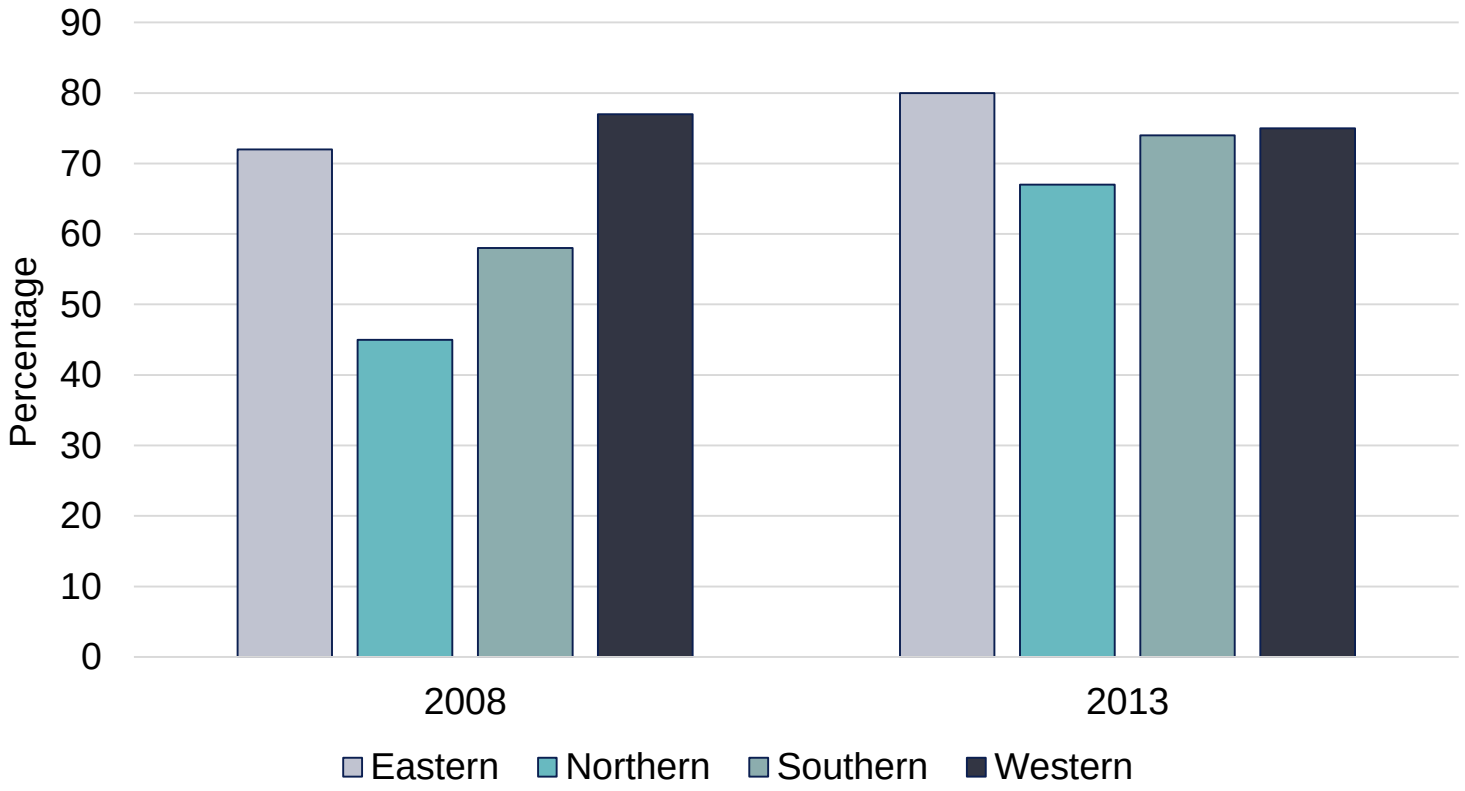
Pro-poor changes in disease prevention for children





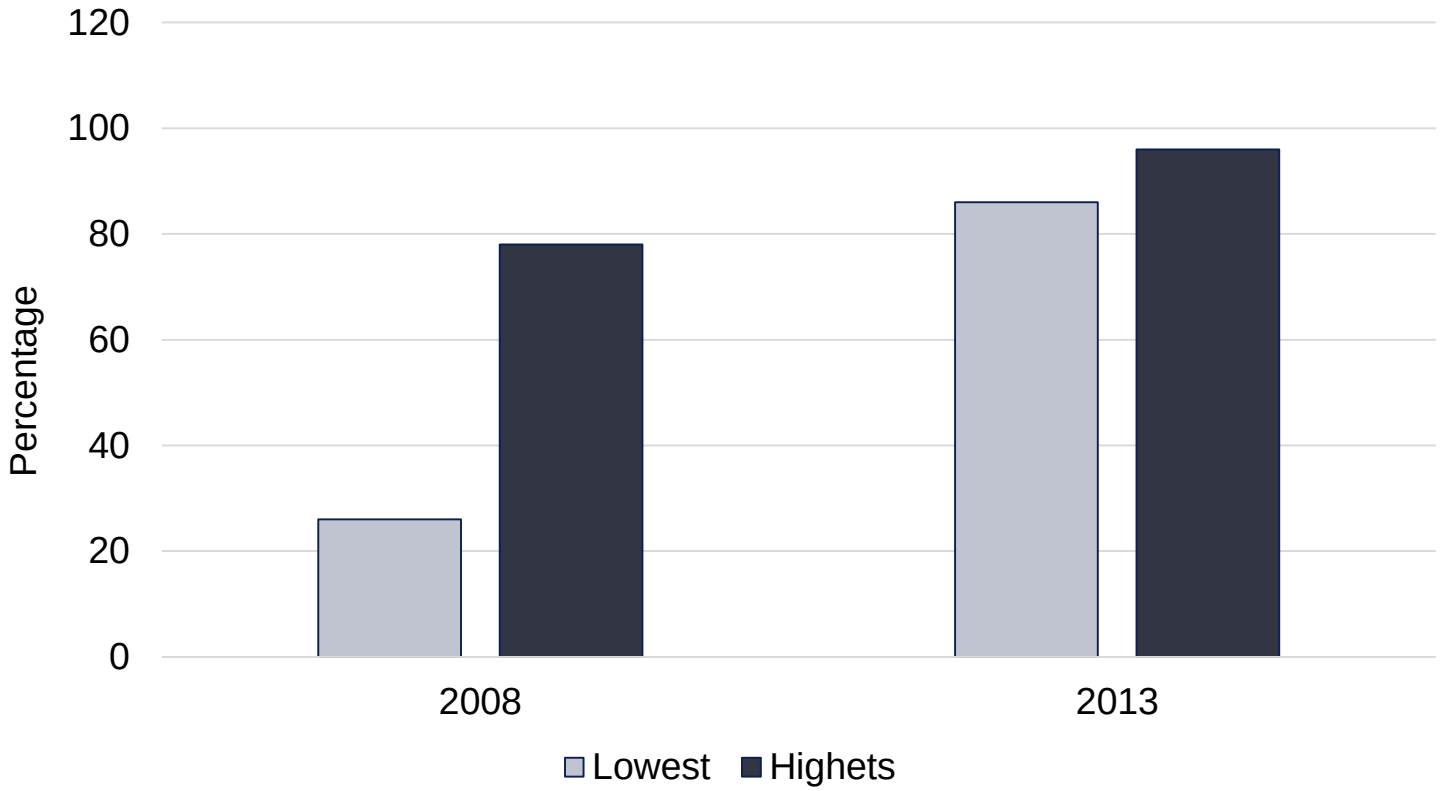
In 2008 the poorest fifth of children had similar or lower immunisation and ITN rates than other quintiles; by 2013 rates for the poorest where as high or higher than all others.

Changes in regional equity: Post-natal care



In 2008 Northern and Southern regions had much lower levels of PNC. By 2013 the gap between these regions and Eastern and Western region had greatly narrowed.

Blood testing during ANC: by wealth quintile



The gap between rich and poor for ANC components has narrowed. For example, blood testing rates for the lowest quintile rose from very low levels so that they almost reached those of other quintiles by 2013

Did the FHCI have a differential impact on different socioeconomic groups or marginalised groups?

- **Improvements in equity across regions** in terms of coverage of services. Eastern Region in particular showed great improvements moving from the worst region to the best during this period for treatment with antibiotics of children with ARI symptoms. This pattern for Eastern Region was also seen in improvements in malaria treatment for children
- Analysis of per capita funding of health through local councils suggests relatively **equal distribution**. The same is true of performance-based financing (PBF) funds. However, other general health system resources such as staff are very unequally distributed, which is a long-standing pattern
- Overall, the ratio of girls to boys visiting a PHU for outpatient care has changed **in the favour of girls since 2011**: in that year slightly fewer girls visited a PHU than boys, whereas by 2013 it was slightly more
- Other access barriers include physical ones, such as distance to facilities and the transport required to reach them. As indicated in the health system pillar analysis, there have been investments in improving infrastructure and referral systems and transport under the FHCI but **distance and transport cost remain significant barriers for remote communities**

6. Were there any unintended consequences of the FHCI?

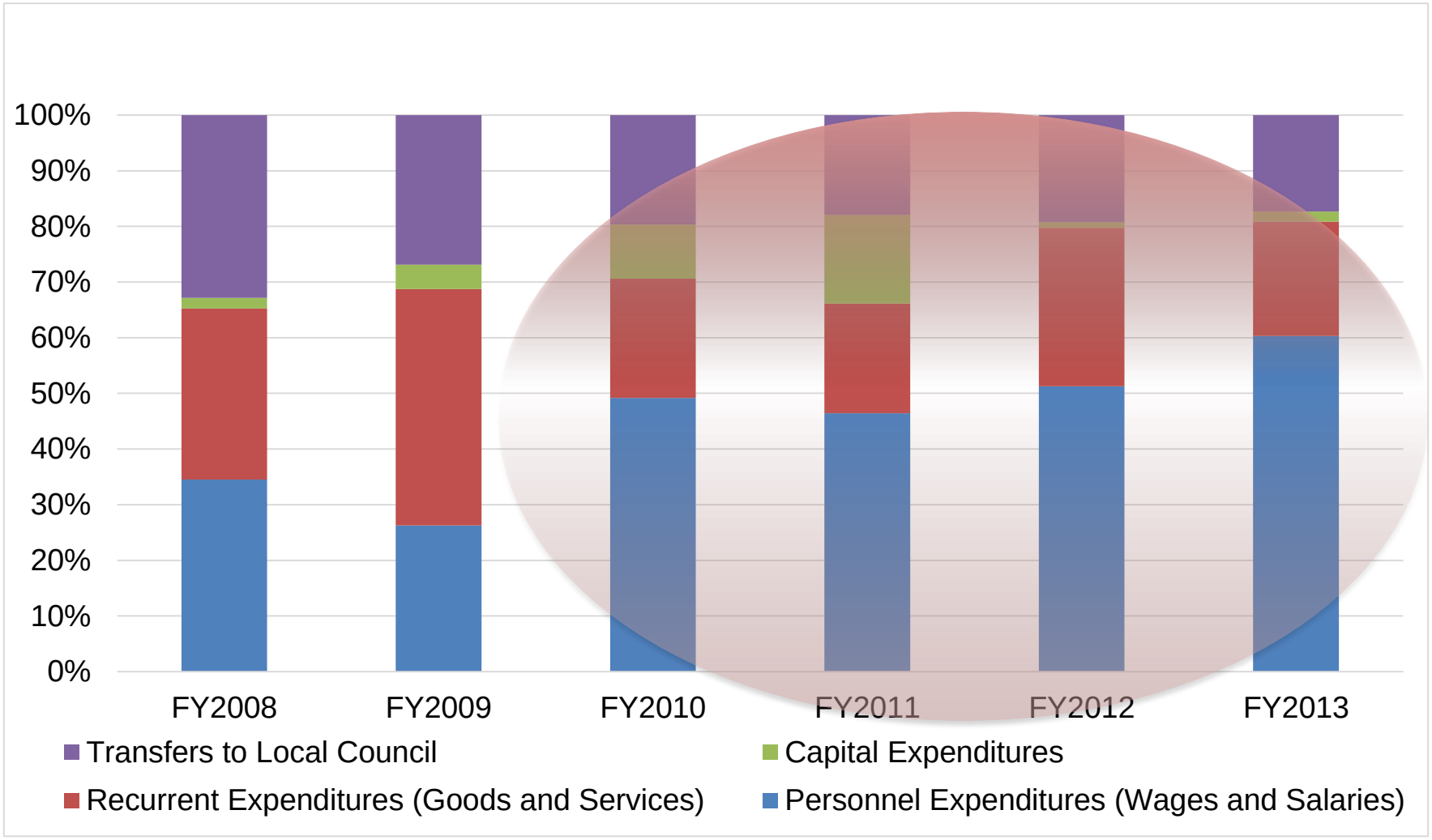
We examined 10 possible unintended consequences of FHCI on the health system and society but only found evidence to support one of them, which was a squeeze on non-salary expenditure within the MoHS budget (mixed story).

- ***rise in teenage pregnancies*****,** presumably because of falling costs of maternal health care? DHS data do not back this up. Fertility rates for 15 to 19 year olds fell from 146 per 1,000 women in 2008 to 125 in 2013. All other age groups showed much smaller reductions in fertility.
- ***drop in preventive services*** (through diversion of resources to curative care)? Not sustained beyond, for example, a known fall in community immunisation rates for children in the early months of the FHCI.
- ***utilisation of public services by non-targeted groups*** such as general adult outpatient visits and those for older children? Trends from 2011 to 2013 appear to show that the number of outpatient consultations has been rising for both FHCI and non-FHCI groups.

Were there any unintended consequences of the FHCI?

- ***women's empowerment*?** we found no evidence that a strong shift in gender roles has occurred.
- ***changes to the health care market*** might be expected to result from the FHCI. In the DHS, there is virtually no change between 2008 and 2013 in terms of private sector use for delivery care: just over 2% of births take place in a non-government health facility in both years.
- A number of potential unintended financial consequences were also explored.
  - ***crowding out of other budget lines*** in the MoHS budget by the increase in salaries awarded in 2010, which was linked to the FHCI. Looking at a breakdown of MoHS expenditure, there were significant decreases in HR management, secondary, and tertiary expenditure in 2011, the first budget that included FHCI expenditure. This may reflect a declining non-payroll recurrent budget (with significant increases in the payroll budget). This is a risk that requires careful management, as expectations of continuing salary increases are easily established.

Main items of MoHS expenditure, 2008-2013

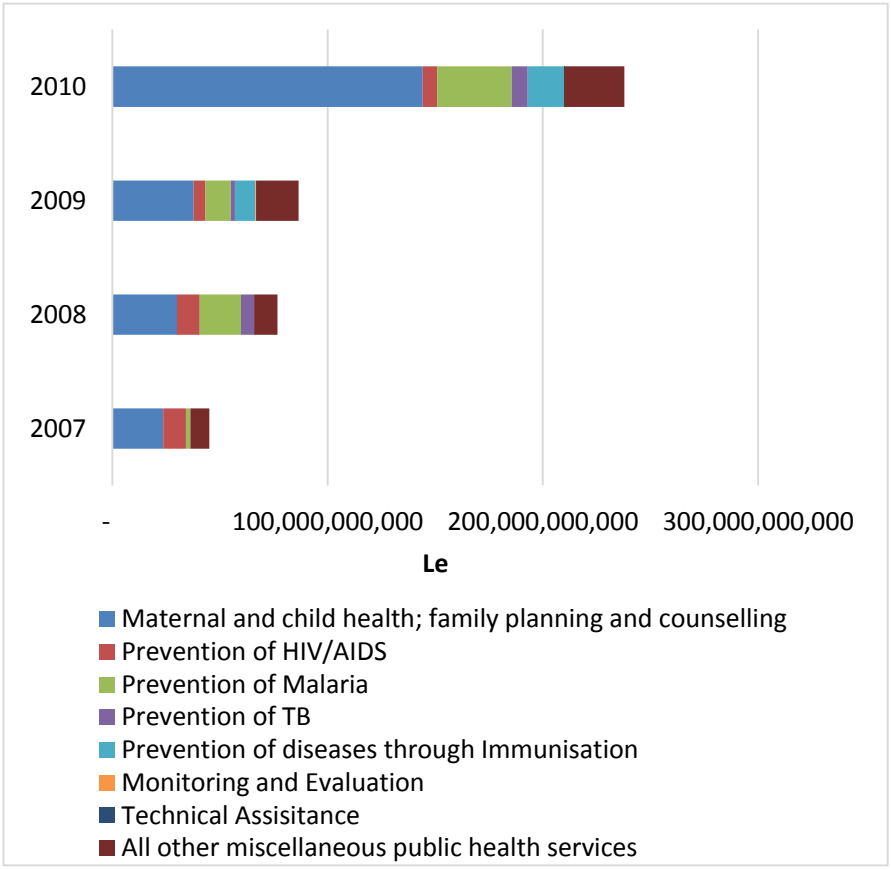


Source: MoHS figures

Were there any unintended consequences of the FHCI?

- ***other programmatic areas squeezed*** by the allocation of funding to the FHCI? This does not seem to have materialised and in any case may have been minimised by some of this funding being off-budget and subject to existing donor programmes.
  - MCH expenditure increased from 8% of non-salary recurrent MoHS expenditure in 2008 to 28% in 2014
  - But also other areas like malaria prevention
  - Inpatient expenditures also reduced, potentially suggesting better first-line treatment

Expenditure by public health area, 2007–2010 (NHA data)



Were there any unintended consequences of the FHCI?

- ***wage increase contagion to other sectors?*** While it is extremely hard to link the causes of salary decisions, aggregate data suggest there may be some cause for concern here. Wages have increased significantly in Sierra Leone since 2010, making up a growing share of the economy, from around 5% of gross domestic product (GDP) in 2009 to a projected 7% of GDP in 2015. However, the increases do appear to be driven by other factors, such as the minimum wage, which was brought in in 2014.
- ***opportunistic responses by facility managers*** to the FHCI, which would include changing the prices for other services to cope with lower or more irregular funds for FHCI target groups. No evidence found to support it. The PBF funds have acted to buffer the losses from FHCI. If they diminish or become more irregular, this risk would be likely to become more real again.

7. Did the FHCI provide value for money?

Cost of the FHCI

- The direct cost of the FHCI for large known items, as an increase on previous funding to similar groups, is around US$ 25 (2010) to US$ 40 million (2013).
  - These are not far off the estimates provided by the MoHS in 2012.
  - These are much higher at US$ 40–90 million if all additional expenditures on these groups are included.
- Direct financing of the FHCI (e.g. payroll, drugs, PBF) equated to an increase of **an additional US$4 (2010) to US$ 6.2 (2013) per capita in government and donor funding**. Broader indirect reproductive and child health (RCH) expenditure adds US$ 2.5 (2010) to US$ 8 (2013) per capita spend per year.

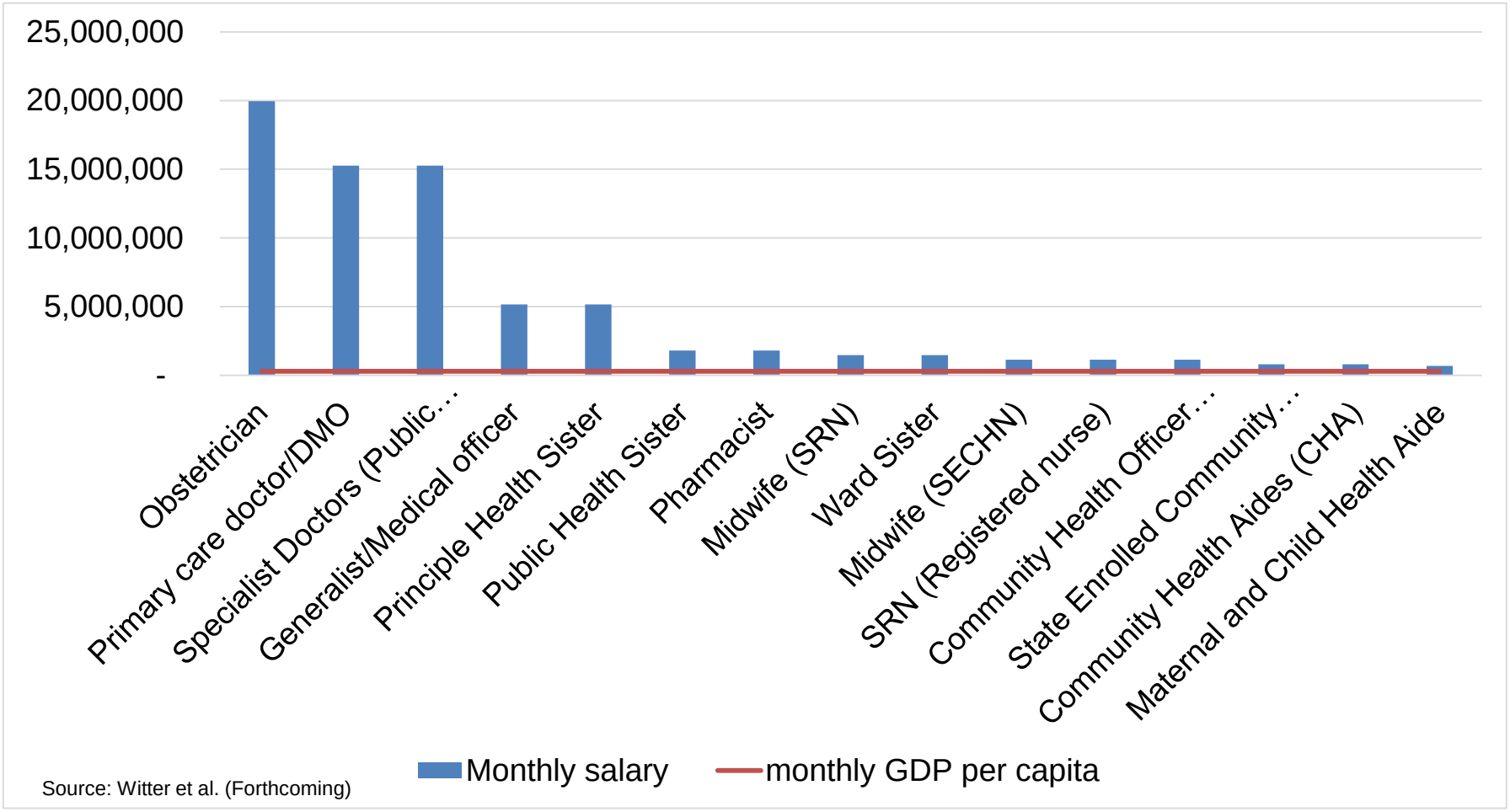
Economy

- 25% of the broader marginal costs of the FHCI was spent on HR and 15% was spent on pharmaceuticals
- For staffing, we cannot comment on changes but can say that doctors are very well paid now – 68 times gross national income (GNI) per capita, compared to 38.5 times in a similar study in Ghana
- Unit costs for drugs are not available for the pre-FHCI period. However, it appears that up to 76% of the drugs procured for the FHCI were available at a lower price elsewhere, indicating that greater economy could be achieved through stronger purchasing

Efficiency

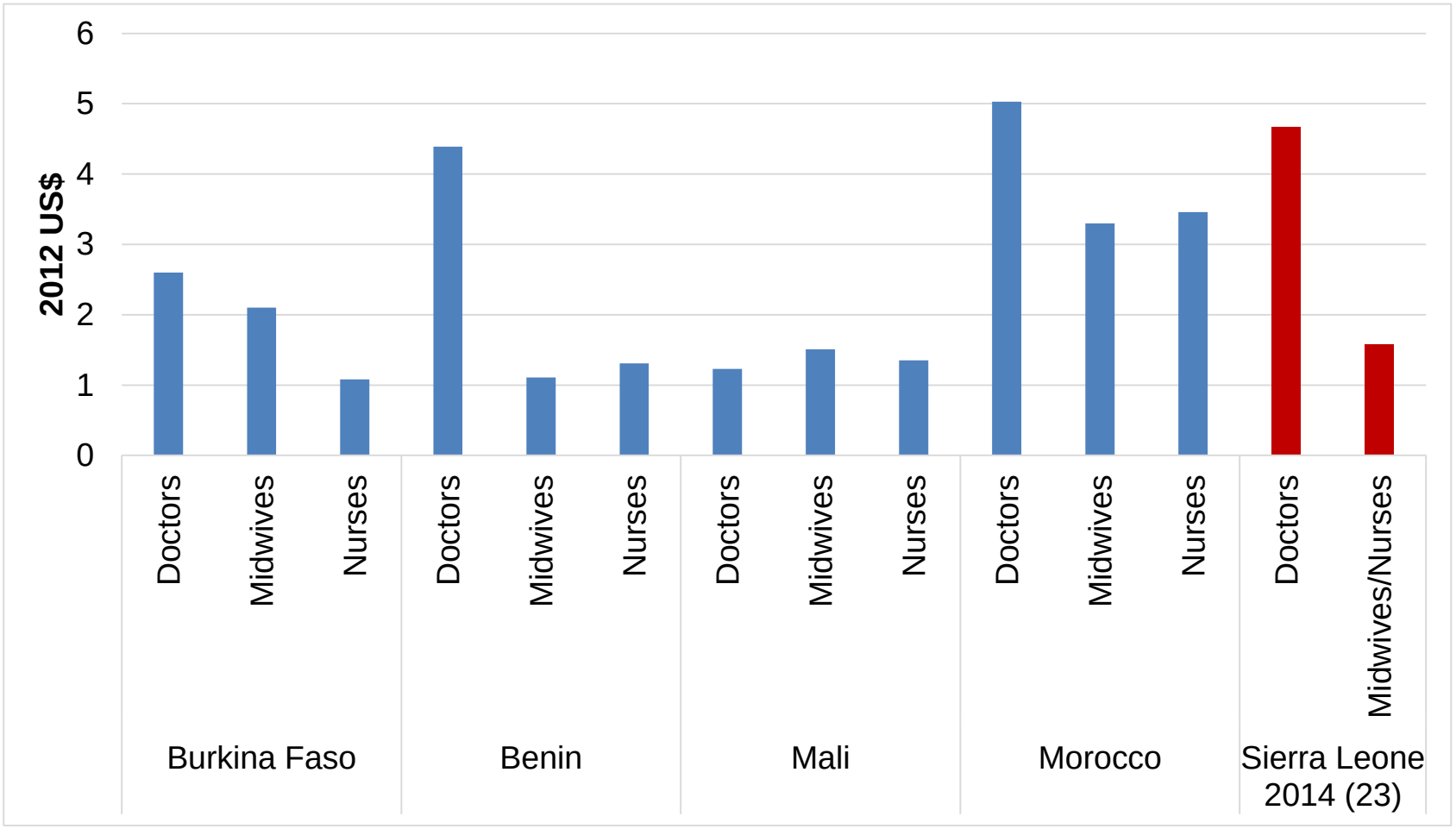
- Delivery, ANC and immunisation of children represent decreasing proportions of total visits and time spent providing care while child outpatient visits, PNC and family planning are increasing their footprint. The cost per visit is decreasing, but at the same time the average visit may be shortening

Health worker salaries in Sierra Leone, 2013



Source: Witter et al. (Forthcoming)

Benchmarking health workers pay/hour across five countries, 2012



Cost effectiveness

	Lives saved	Life years saved
Newborn	6,300 – 7,600	239,400 – 270,100
Child	13,600 – 13,800	288,300 – 290,700
Maternal	1,500 – 1,600	31,400 – 35,800
Marginal effects (A)	**561,500 – 594,200 life years saved**	
Marginal costs (B)	**249.56m US$**	
Cost per life year saved (=B/A)	**US$ 420 - 445**	

- In 2013, the GDP per capita in Sierra Leone was US$ 680 according to the World Bank's World Development Indicators.
- On these thresholds, our estimates of cost per life year saved indicate that the **FHCI was a very cost-effective intervention**.
- These findings, though modelled, are consistent with the estimates generated by our outcome analysis.

Sustainability

- **Donors have provided between 60% and 80% of the new funding to the FHCI, outside of household financing**
  - Government expenditure on health per capita increased from US$ 3.1 in 2009, to US$ 5.2 in 2010 and US$ 6.5 in 2011 (although these were more modest increases in real terms), suggesting that the FHCI continued the upward progress from 2009, although expenditure remains very low
- **Dependence on short-term external technical assistance** - momentum has slowed as these 'enablers' pull out and MoHS struggles with multiple priorities and limited staff.
- **Political commitment to the FHCI remains strong** – the policy is still a presidential flagship programme, included in major national plans, and there is strong public demand and expectation.
  - However, new areas of emphasis in the post-Ebola period raise the risk that improving and deepening the FHCI could be neglected.
  - In addition, longer-term institutional challenges remain, such as establishing an effective procurement agency and strengthening the MoHS capacity overall.
- There is a general **social consensus** in our qualitative research that it targets a priority group, but :
  - naturally gives rise to heightened expectations from other population groups.
  - implementation failures undermine positive experiences and social perceptions

Conclusion

1. The FHCI responded to a clear need in Sierra Leone
2. It did indeed bring funds and momentum to produce some important systemic reforms
   - Underlying this achievement was strong political will, which has been sustained, enhanced donor cooperation, the deployment of supportive technical assistance, and consensus among stakeholders that the FHCI was significant and worth supporting.
3. However, weaknesses in implementation of this ambitious policy have been evident in a number of core areas, such as drugs supply.
4. We conclude that the FHCI was one important factor contributing to improvements in coverage and equity of coverage of essential services for mothers and children.
   - Other important contributors have probably been the other RMNCH investments that would have continued in the absence of the FHCI and broader economic changes. Clearly Ebola in 2014/15 also plays a major role in eroding previous gains.
5. Whether the FHCI contribution fed through into improved health is less clear from the data, although there was a very sharp drop in under-five mortality associated with the start of the initiative.
   - Modelled cost-effectiveness is high – in the region of US$ 420 - US$ 444 per life year saved.

Recommendations: cross-cutting

One central recommendation: renew and deepen commitment by continuing the reforms that were started in 2010. More specifically:

- **Bring a relentless focus to bear on quality of care**
  - Clear standards and protocols for the basic package should be developed and incorporated into training and supportive supervision.
  - Indicators to monitor technical quality of care are lacking and should be built into routine systems.
  - Indicators of responsiveness and respectful treatment should also be incorporated into surveys.
  - It would also be useful to repeat the EmONC needs assessment carried out in 2008 (UNFPA, 2008) in order to assess progress in key domains.
- **Address wider barriers to access**
  - E.g. engaging communities in supporting transport to facilities, spreading information about entitlements and the benefits of health services, and raising awareness of danger signs for women and children.
  - Stronger inter-sectoral collaboration with other ministries such as the Ministry of Education and the Ministry of Social Welfare, Gender and Children's Affairs
- **Deepen decentralisation**
  - E.g. long-term work around some of the structural PFM issues for funding of districts, including timeliness and capacity to report on funds
  - Strengthening capacity of DHMTs to plan, supervise and monitor donor and public programmes and close the policy-to-practice gap

Recommendations: governance

- **Invest in institutional development** of the MoHS to steward the policy and health system
  - E.g. avoiding parallel programmes and systems
  - boosting planning capacity and the staffing, capacity and role of the health financing unit and the key directorates
- The development of a **health financing strategy** is desirable to provide coherence between the FHCI and other policy strands.
- **Specifically on the FHCI, there needs to be better communication and planning** between the Cabinet, MoFED and the MoHS, including clear leadership on the policy
  - agreed forward plan, based on projected needs and resources (our fiscal space analysis can be starting point for this)
- Introduce **greater accountability**
  - agree plans and commitments, with incentives and sanctions incorporated
  - also greater transparency to monitor performance
- **Strengthen community engagement**
  - Going beyond civil society monitors
  - Learning lessons from Ebola experience

Recommendations: health financing

- Provide **additional funds** to the health sector to reduce OOP spending
  - But in addition, addressing the systemic problems with HR and provision of drugs and supplies are among the important ways to reduce the need for household OOP spending
- **Tax revenue collection** is a priority and will continue to require reform over the next 10 years
- There is some evidence that **earmarked taxes could be supported**:
  - current tax-to-GDP ratio of 9%, compared to the low-income average of 17% or even the fragile state average of 14%
  - sin taxes (earmarked taxes on tobacco and/or alcohol), withholding taxes (in this case taxes on contracts) and an airline levy are most promising
  - Note that the withholding tax being considered for implementation will not cover FHCI costs; issue of how it is to be managed and used also requires more discussion and agreement
- There are not enough domestic resources to pay for the requirements of the FHCI, or UHC, in the next 10 years so **continued and increased donor support** is needed.
  - However, there is also a strong argument for improving PFM to encourage on-budget external funding.
  - hybrid solutions such as using common and mutually agreed indicators for release of funding and using GoSL supply and procurement systems for donor-financed goods should proactively be explored
- **Provide more flexible financing to the local level**
  - Including revisiting the potential for strengthening of the PBF system
- **There is a need for investment in improving data on health financing** In particular, two areas stand out:
  - Improved M&E for capturing the true costs of the FHCI; and
  - Improved methods for measuring OOP payments.

Recommendations: planning, monitoring and evaluation

- **This policy should continue to be led at the RCH Directorate level** or be clearly housed in a MoHS directorate that takes ownership of it
- **The main challenge in terms of M&E is to develop and implement a robust and comprehensive M&E strategy for health**. This should include the monitoring of the whole results chain (inputs, outputs, outcomes) and also specifically those strategic areas where data have been weak until now, i.e. quality of care, staffing, drugs and financing. The M&E strategy should cover the following key areas:
  - Consultation with key data users on what to collect and how frequently;
  - Improving the quality and coherence of the various data sources;
  - Publishing and distributing health data analysis in user-friendly formats such as dashboards of indicators, regular health bulletins and more extensive research and analysis; and
  - Increasing the demand for and use of health information, particularly through health sector reviews and accountability processes.

Recommendations: human resources for health

- Improve the **management of the payroll**, including:
- **Decentralisation of HR functions** to the district level is needed to ensure greater responsiveness to district needs and a greater ability to performance manage staff effectively.
- At the same time, **HR management capacity at central level should urgently be strengthened**
- Given the inequalities in distribution of staff and staff shortfalls in some key cadres, the MoHS should develop **integrated and sustainable packages to retain qualified staff** in remote areas and in shortage cadres
- There also needs to be a **clearer definition of the roles and funding** of the different types of staff and close-to-community providers, such as TBAs and CHWs
- **Revising training curricula and strengthening training institutions** – also assessment of staff competences and support for continuous professional development, which are lacking to date.
- **Supportive supervision** should be promoted and resourced
  - Focus on effective and appropriate care, responsiveness, ensure informal charging stops
  - Better communication and streamlined reporting to reduce burden

Recommendations: infrastructure, drugs and supplies

- **Urgent investment is needed to bring key health infrastructure up to acceptable standards and maintain it**
- Connect rural health posts with district hospitals and improve the referral system by **reconditioning dozens of Ebola ambulances** donated by aid agencies, and continuing to explore the feasibility of a national ambulance service.
- **Implement a 'pull' system for drugs across all hospitals and PHUs**
- **Support the simplification of forms to be filled in by hospitals and PHU.**
  - CHAI has designed forms for each type of facility (MCHP, CHP, CHC and hospitals), so that they reflect the drugs and medical supplies for the type of services they provide.
  - A new LMIS system ('M Supply') is also being piloted, which seems to be addressing some of the issues identified in CHANNEL.
  - **Investment in developing an effective monitoring system is essential for an adequate management of the supply chain at all levels.**
- **Build adequate storage facilities and ensure the SOP Manual is implemented**
  - E.g. enforcing the FEFO policy so as to minimise wastage
- **Allocate a fixed budget for the supply chain**
  - In addition, the new NPPU will require transparent governance and sufficient human and financial capacity to function effectively

Recommendations: communications

- Since a lack of communication can have a negative impact on the success of any policy, it is recommended that **a communications budget is allocated at the very start of any future reform**.
- **Communications need to be integrated across all initiatives** and a longer-term approach to information, education and communication developed.
- **Engaging the implementers and addressing their concerns** should always precede communication to the public.

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Thank you