World Health Organization
REGIONAL OFFICE FOR Africa

WHO COUNTRY COOPERATION STRATEGY 2008-2013

SIERRA LEONE

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ABBREVIATIONS

AFRO	:	Regional Office for Africa (of WHO)
AIDS	:	acquired immunodeficiency syndrome
BCG	:	Bacille-Calmette-Guérin
CCS	:	Country Cooperation Strategy
CDS	:	Communicable Diseases and Surveillance
DFID	:	Department for International Development (of the United Kingdom)
DP	:	development partner
EHA	:	Emergency and Humanitarian Action
EPI	:	Expanded Programme on Immunization
EU	:	European Union
FCH	:	Family and Community Health
GDP	:	Gross Domestic Product
GFATM	:	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMP	:	Good Manufacturing Practices
GSM	:	WHO Global Management System
HIV	:	human immunodeficiency virus
HQ	:	Headquarters (of WHO)
HSD	:	Health Systems Development
IMCI	:	Integrated Management of Childhood Illness
IST	:	Intercountry Support Team (of WHO)
IVD	:	Immunization and Vaccine Development
LDHS	:	Sierra Leone Demographic and Health Survey
MDG	:	Millennium Development Goal
MIS	:	Management Information System
MOHS	:	Ministry of Health and Sanitation
MTSP	:	Medium-term Strategic Plan
NEPAD	:	New Partnership for Africa's Development
NCD	:	noncommunicable disease
NGO	:	nongovernmental organization

OPV	:	oral polio vaccine
PHC	:	primary health care
PRS	:	Poverty Reduction Strategy
RB	:	regular budget
RCH	:	Reproductive and Child Health
SWAp	:	sector-wide approach
TB	:	tuberculosis
TT	:	tetanus toxoid
UN	:	United Nations
UNDAF	:	United Nations Development Assistance Framework
UNICEF	:	United Nations Children's Fund
USAID	:	United States Agency for International Development
WB/IDA	:	World Bank/International Development Association
WCO	:	WHO country office
WHO	:	World Health Organization

PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa

EXECUTIVE SUMMARY

The Country Cooperation Strategy (CCS) defines a medium-term vision, the strategic framework for the work of WHO with a country and clarifies the Organization's strategic priorities in supporting the country's national health and development agenda. It clarifies the proposed roles and functions of WHO in supporting the country's national health and development agenda. This document presents an analysis of information on country health and development challenges, development assistance, aid flow and partnerships for health development, current levels of WHO cooperation and support, and the WHO policy framework including global and regional directions, the new strategic agenda for the country office for the period 2008-2013 and their implementation.

The first WHO CCS for Sierra Leone was formulated for the period 2004-2007 and focused on health transition from emergency to recovery and development, rehabilitation of the health system, disease prevention and control, health promotion, reproductive, child and adolescent health and strengthening national health system. WHO supported the Ministry of Health and Sanitation and partners to make a significant difference in each of these areas and to the overall health status of the country.

The development of the second generation CCS involved extensive consultations with all key stakeholders, including the Ministry of Health and Sanitation and the development partners in Sierra Leone. This was to ensure alignment with key national and international priorities, including the Millennium Development Goals, the Sierra Leone Vision 2025 and the MOHS Medium Term Rolling Plan (2008-2010) and PRSP II (2008-2010). Review of the CCS noted that WHO was establishing itself as the country's principal source of credible, trusted and evidence-based advice and technical support in the health sector. However, the partners' perception of WHO's performance and contributions needs to be improved. The skill mix of staff and competencies of the WCO team needs to be broadened to improve on the changing needs.

This new Sierra Leone CCS articulates the strategic priorities for WHO's collaborative work in Sierra Leone for the period 2008–2013. The strategic priorities are rooted in WHO policies and strategies, aligned with national priorities, and harmonized with the work of United Nations and other partners in Sierra Leone, as encapsulated in the UNDAF and joint UN Vision for Sierra Leone. The WHO global and regional policy frameworks have provided vital directions for the CCS 2008-2013. The Eleventh General Programme of Work (GPW), currently the highest policy document for WHO, provides a global health agenda that is aimed at all health agencies internationally. WHO, as the global health organ of the United Nations, contributes to this agenda by concentrating on its core functions which are based on its comparative advantage. The regional priorities have been expressed in the "Strategic Orientations for WHO Action in the African Region 2005-2009". To ensure effective support for Sierra Leone, the WHO Country Focus Policy will gear the operations of WHO to the needs of the country.

In order to ensure effective implementation of the Sierra Leone CCS 2008-2013, implications for the WHO country office in Sierra Leone, the WHO Regional Office for Africa (AFRO) based in Brazzaville, as well as for the WHO headquarters (HQ) in Geneva are outlined. The implications of the CCS 2008-2013 for the WHO country office (WCO) in Sierra Leone are outlined in terms of the following: expanding the use of the Country

Cooperation Strategy; core competencies and capacities of WCO Sierra Leone team; integrated programmatic and technical support from Regional Offices and Headquarters; effective functioning of the country office; knowledge management and information; and working with organizations of the United Nations system and development partners.

The overarching principles of the CCS 2008-2013 are a commitment to primary health care and health service strengthening, gender mainstreaming, human right to health and equity. The strategic agenda of the WHO Cooperation Strategy will comprise four strategic priorities.

Strategic Priority 1: reduction of health, social and economic burden of communicable and noncommunicable diseases: the main focus will be strengthening the prevention and control of malaria, combating HIV/AIDS and Tuberculosis and enhancing capacity of the national immunization programme for effective prevention and control of vaccine-preventable diseases. As a strategic approach, the support for effective integrated disease surveillance; preparedness, response and control of communicable diseases, including the implementation of International Health Regulations; prevention and reduction of non-communicable conditions; as well as the promotion of health and development will be addressed.

Strategic Priority 2: reduction of infant, child and maternal morbidity and mortality, and promotion of responsible and healthy sexual and reproductive health behaviour: the main focus will be increased support to the MOHS and the newly established RCH department. WHO will continue to support capacity building that aims to improve the health of mothers, children, adults and the ageing population through a life-cycle development approach but with special attention to universal access to quality sexual and reproductive health, family planning and adolescent health. In line with the rights-based approach to sexual health, the reproductive health needs of both gender will be addressed. A community focus and adherence to the principles of PHC will remain central to WHO support.

Strategic Priority 3: strengthening policies and systems to improve access and quality of services: through comprehensive health systems development at national, district and sub-district levels, implementation of the Sierra Leone Vision 2025 health agenda and the MOHS Rolling Plan (2008-2010) to ensure increased utilization levels and enhance the impact of health services, strengthening of the capabilities of MOHS in collecting and analyzing financial information for decision making, and strengthening human resource capacities at all levels.

Strategic Priority 4: fostering partnerships and coordination for national health development: through technical assistance to the MOHS and development partners in support of the implementation of health sector programmes. In addition, WHO will continue its liaison function with respect to global alliances/funds, foundations and nongovernmental organizations.

The Country Cooperation Strategy 2008-2013 will be financed and operationalized through three consecutive biennial programme budgets and workplans. Within the framework of the WHO results-based management system, these workplans include a robust monitoring framework of intervention-specific indicators. Periodic in-depth evaluations of selected programmes as well as thematic evaluations to determine their outcomes and impact on national health development shall be undertaken, when necessary, in order to ensure that the WHO Country Cooperation Strategy contributes significantly to the achievement of better health for the people of Sierra Leone.

SECTION 1

INTRODUCTION

The Country Cooperation Strategy (CCS) reflects a medium-term vision and defines the strategic framework for cooperation between WHO and Member States. It clarifies the proposed roles and functions of WHO in supporting the country's national health and development agenda. The first WHO CCS for Sierra Leone was formulated for the period 2004-2007. This 'SECOND GENERATION' CCS brings improvements in the quality of the CCS processes and document – involving better analyses of challenges and opportunities at country level, improvement in the selectivity and alignment of the strategic agenda (strategic priorities and approaches) with national priorities as well as harmonization with the priorities of partners in Sierra Leone.

As an organization-wide reference for country work, the CCS presents a basis for developing the "WHO one country plan and budget" and is used for mobilizing human and financial resources for strengthening WHO support to countries. In a two-way process, it feeds into, and takes into consideration, both the General Programme of Work and the Programme Budget.

The Sierra Leone programming environment has transited from an emergency/conflict situation phase into a peace building and accelerated development phase. Furthermore, there have been many regional and global developments in the health and socioeconomic arena that have influenced WHO actions. Additionally, the WHO Eleventh GPW 2006-2015 and the WHO Medium-term Strategic Plan (MTSP) 2008-2013 have provided new directions for the Organization's engagement with countries, and these issues need to be harmonized with the WHO Cooperation Strategy. This CCS articulates the strategic priorities for WHO's collaborative work in Sierra Leone for the period 2008–2013. The strategic priorities and the main focus of the new strategic agenda has taken into account the demographic and epidemiological contexts, emerging health issues and changing health priorities in the country, as contained in the Sierra Leone Vision 2025 and the Sierra Leone National Health Strategic Plan 2004–2007.

The CCS for 2008-2013 was developed through an interactive consultation and planning process involving government officials, development partners and other stakeholders. Under the leadership of the WHO Representative, the CCS development team conducted in-depth reviews and analysis of the key health sector issues, including the factors that influence the health status of Sierra Leoneans, held broad consultations and advocacy for the CCS 2008-2013 preparation process, and secured the active involvement of key stakeholders, including the MOHS, UN partners and WCO staff. The consultation process also involved the WHO Regional Office for Africa (AFRO) to ensure that country-specific needs and potentials are in line with regional priorities. All efforts were also made to ensure that the strategic agenda for the work of WHO in Sierra Leone is aligned with key national and international development priorities including the United Nations Development Assistance Framework (UNDAF) for Sierra Leone, NEPAD, and the Millennium Development Goals (MDGs) (see Annex II for details of the CCS development process).

This document presents an analysis of information on country health and development challenges, development assistance, aid flow and partnerships for health development, current levels of WHO cooperation and support, and the WHO policy framework including global and regional directions. WHO will fund and operationalize the CCS for 2008-2013 through three consecutive WHO biennial budgets and workplans. This CCS document outlines WHO's strategic priorities and the main focus that would be the focus of WHO's work during the period 2008-2013, and identifies their implications for the work of the WHO Secretariat at the country, regional and HQ levels toward contributing to the achievement of better health for the people of Sierra Leone.

Guided by the Country Cooperation Strategy as a road map, WHO will direct its efforts at maximizing synergies and complementarities with the MoHS, and development and other health partners to contribute to the global targets in the medium term.

SECTION 2

COUNTRY HEALTH AND DEVELOPMENT CHALLENGES AND NATIONAL RESPONSE

2.1 SOCIOECONOMIC DETERMINANTS OF HEALTH

Table 1: Socioeconomic Development Indicators

Indicator	Value
Population Size *(de jure) (2008, est)*	5,473,530
Annual population growth rate (%) (2008)	2.3
Population urbanized (%) (1996)	30
Life expectancy at birth (2007)	49.4
Total fertility rate	6.3
Contraceptive prevalence (%)	5
GDP per capita (PPP, US$) (2007)	700
Population below poverty line (%) (2004)	70.2
Adult literacy rate (%) (2002/3)	25%
Net primary school attendance rate (%) (2004)	48
Net secondary school attendance rate (%) (2004)	19
Marriage before age 15 (%)	27
Marriage before age 18 (%)	62
Human Development Index Rank (out of 177 countries) (2004)	177

Source: Multiple Indicator Cluster Survey (MICS 3) 2005; EPI MOHS Report 2007; Census 2004 (Projection 2007) SL

Sierra Leone is located in the West African coast, bounded on the west by the Atlantic Ocean, on the north and east by Guinea and on the southeast by Liberia. Population movement across these borders is very high, and the three countries have recent histories of insecurity and civil strife. Sierra Leone has a surface area of 71 740 square kilometres. This tropical country averages an annual rainfall of 3 150 mm and rainfall along the coast can reach 495cm a year, making it one of the wettest places along the coastal western Africa, and can also cause occasional floods. The vegetation ranges from mangrove along the coast to forest covered hills and savannah further inland, which can harbour some vectors of diseases.

Administratively, Sierra Leone is divided into the Western Area and three provinces – Eastern, Northern and Southern provinces. About two thirds of the population live in rural areas while a third live in urban areas, mainly in the capital city of Freetown. The population of Sierra Leone, estimated 5.5 million in 2008, has a natural increase rate of 2.3, with children 0-14 years representing about 45% of the population. The crude birth and death rates are 45 and 22 per 1 000 population, respectively. The total fertility rate, estimated at 6.3 per woman, is amongst the highest in the world. However, life expectancy at birth is estimated at 49.4 years, and is associated with the high child and maternal mortality rates, as well as the heavy

burden of communicable and noncommunicable diseases in the country. The underlying factors are pervasive poverty, high level of illiteracy especially among females, limited access to safe drinking water and adequate sanitation, poor feeding and hygienic practices, and overcrowded housing and limited access to high quality health care services.

Leadership and Governance

Sierra Leone is politically a constitutional democracy. The Parliament of Sierra Leone is unicameral, having one chamber that has 124 seats. The country gained independence from Britain on 27 April 1961 and became a Republic on 19 April 1971. Between 1961 and 1990, the country witnessed steady development of constitutional democracy, rule of law and transparent governance of national institutions, the basis for enduring health and socio-economic development. The civil war which lasted from 1991 to 2002, destroyed basic health infrastructure and displaced health personnel, compromising healthcare at all levels in the country.

With the support of the United Nations and developmental partners, Sierra Leone commenced the rebuilding of governance infrastructure, beginning with the disarmament and demobilization of ex-combatants in February 2002. This was followed by successful presidential and parliamentary elections on 14 May 2002. About five years after, on 28 July 2007, another parliamentary and presidential election took place, which witnessed the transition of power from the then ruling party to hitherto opposition party. This transition is a major milestone in the re-establishment of a robust constitutional democracy in the country and marked the end of the recovery phase and the beginning of the peace building and development phase of post-conflict Sierra Leone.

Economic and Social Development

Sierra Leone ranks as the least developed country in the world, based on its 2007 Human Development Report ranking of 177 out of 177 countries[1]. The country is extremely resource-poor, with a GDP per capita (PPP) of US$ 700; it ranked 102 out of 108 countries in the Human Poverty Report, with Human Poverty Index (HPI) of 51.7[2]. Nearly half of the working-age population engages in subsistence agriculture. The fate of the economy depends on the maintenance of domestic peace and the continued receipt of substantial external aid, which is essential to offset the severe trade imbalances and supplement government revenues.

However, progress is being made especially in creating an enabling environment for socioeconomic development. In response to these socioeconomic challenges, the government of Sierra Leone has developed the Sierra Leone Vision 2025 and the Sierra Leone Poverty Reduction Strategy (PRS) that guides the government's efforts toward improving the current socioeconomic situation. Intercountry collaboration is carried out through the Mano River Union (MRU) as well as the Economic Community of West African States (ECOWAS). In 2006, the economy witnessed an overall impressive performance with real GDP growth estimated at 7.8%. Growth was driven by a revitalized bauxite and rutile mining sector, coupled with sustained agricultural output and service delivery.

[1] Human Development Report (2007/2008) Human Development Index rankings: Country Fact Sheets Sierra Leone. Http://hdrstats.undp.org/countries/country_fact_sheet).

[2] Human Development Index Report 2007.

The support of developmental partners was pivotal: disbursements for budgetary support in 2007 was US$6 1.52 million, contributed mainly by the European Union (EU) (US$ 12.57m), the United Kingdom Department for International Development [DFID] (US$18.23m), the African Development Bank (US$ 7.77m) and the World Bank (US$10.23m). Development assistance was also received from IFAD, IDB, BADEA, USAID and the Governments of China, Libya, Japan, Iran, Malaysia and Morocco.[3]

The long-term economic outlook for the country is good. The International Monetary Fund (IMF) completed a Poverty Reduction and Growth Facility (PRGF) in 2005 that helped to stabilize economic growth and reduce inflation. In May 2006, the IMF approved a three-year successor arrangement (PRGF 2) for Sierra Leone of US$ 46.3 million, in support of the Government's 2006-2008 Economic Recovery Programme. Sierra Leone reached the completion point status under the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative in December 2006. The country also qualified for additional debt relief under the Multilateral Debt Relief Initiative (MDRI). An Improved Governance and Accountability Pact (IGAP) aimed at streamlining conditionalities for direct budgetary support, has been signed between the Government of Sierra Leone (GoSL) and the African Development Bank, United Kingdom (DFID), European Commission (EU) and the World Bank. It is expected that significant additional resources will be available for the Government's efforts toward attaining the Millennium Development Goals by 2015.

2.2 BURDEN OF COMMUNICABLE DISEASES

2.2.1 Burden of Malaria

With an under-five mortality rate of 267/1000 live births, Sierra Leone has the highest under-five mortality in the world, and malaria is the number one cause of deaths. For the entire population, malaria burden is very heavy: malaria cases were more than 500 per 1000 population in 2003 and about 330 per 1000 in 2007 (see Fig.1). The disease accounted for about half (48%) of all outpatient consultations[4], and remains a major threat to socioeconomic development.

In children under five years, the disease accounted for 50%-60% of all admissions, and about a third of the children may die (case fatality rate of between 16%-33%). Malaria also accounts for 70% of anaemia among pregnant women.

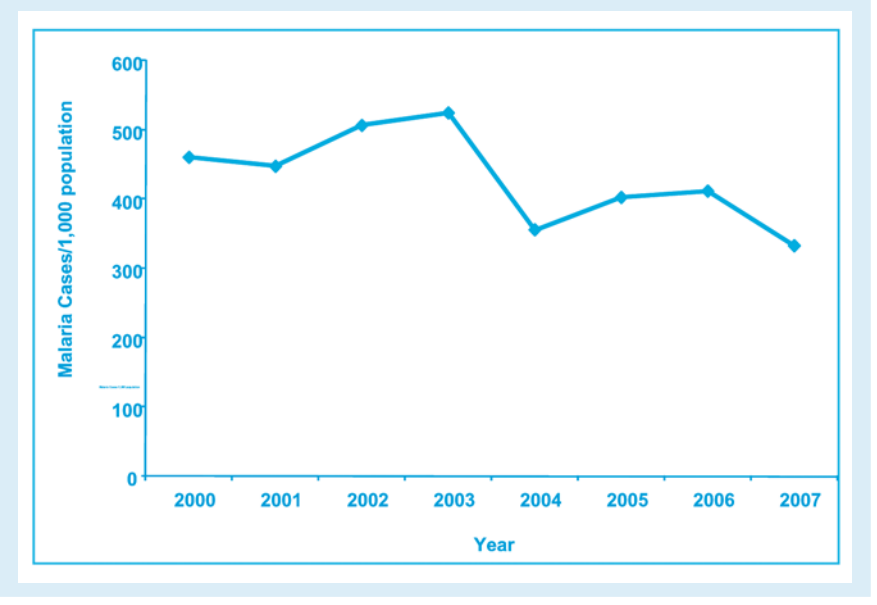
In 1994, the MoHS, with the support of WHO, established the National Malaria Control Programme (NMCP). The strategic priorities of malaria prevention and control in Sierra Leone are case management, vector control, prevention of malaria-in-pregnancy and health promotion[5]. A Roll Back Malaria baseline survey conducted in 2005 revealed that 10.3% of under-fives and 12.5% of pregnant women slept under insecticide-treated nets (ITNs). These figures rose to 78% and 61% for children under five and pregnant women respectively following a national joint measles-malaria (ITN distribution) campaign conducted in 2006[6].

Malaria transmission is all year round in Sierra Leone: the endemicity ranges from meso-endemic to hyper/holoendemic, and the prevalence rate of infection is about 65%. Parasite distribution is *Plasmodium falciparum* (90%), with mixed infection occurring occasionally

[3] Sierra Leone National Health Account Report.
[4] Roll Back Malaria Baseline Survey 2005.
[5] National Strategic Plan for Malaria Control in Sierra Leone, 2004-2008 (March 2004).
[6] Coverage of malaria control interventions in the eight Global Fund districts in Sierra Leone, March 2007.

with *Plasmodium malariae* and *Plasmodium ovale*. In 2004, the first line treatment for uncomplicated malaria was changed from chloroquine to Artesunate-Amodiaquine, with artemether-lumefantrine as the alternative medicines in cases of contraindications or adverse side effects to the first option. ACT implementation is now nationwide. In 2007, Home Management of Malaria Strategy was adopted. Intermittent preventive treatment (IPT), through

Figure 1: Trend of Malaria Cases (per 1000 population) in Sierra Leone, 2000 – 2007



the administration of two doses of sulfadoxine pyrimethamine during pregnancy has also been scaled up nationwide. Sierra Leone received more than US$36 million for malaria control from the Global Fund's rounds 4 and 7.

The presence of oral artemisinin monotherapies and other counterfeit antimalarial drugs is a challenge. To minimize this, WHO supported the establishment of a Pharmacovigilance Unit at the Pharmacy Board of Sierra Leone, to monitor drug safety and efficacy. The Pharmacovigilance Unit received membership status from *the* WHO Uppsala Drug Monitoring Center in August 2008. However, major challenges to the programme scale-up process remain. These include the limited population coverage of ITNs to achieve universal access and coverage, poor ITNs utilization by pregnant women and children under five and inadequate access to ACTs. Environmental changes are also leading to an increase in breeding sites for mosquitoes. Besides, poor patient compliance to the ACTs, poor adherence to the new treatment policy by private practitioners and difficulty of access to adequate health services by the rural and hard-to-reach populations remain major challenges.

2.2.2 Increasing Burden of HIV and AIDS

HIV and AIDS are fast becoming threats to social and economic development in Sierra Leone. The national sero-prevalence survey conducted in 2005 estimated a rate of 1.53% compared to 0.9% in 2002. The highest prevalence among women occurred in the 20-24 years age group (2.0%) whereas males between 35-39 years had the highest prevalence (3.5%). Prevalence in urban areas was 2.1% compared to 1.3% in rural areas, and about 47% of the total numbers of infections were new infections.

The ANC sentinel survey of 2007 revealed a doubling of the prevalence rate: 4.4% compared to 2.5% in 2003. It is also noteworthy that the prevalence of HIV and AIDS is about three times higher among those with tertiary education; it ranges from 1.2% among those with no education to 3.8% among those with tertiary education.

Services such as voluntary confidential counselling and testing (VCCT), prevention of mother-to-child transmission (PMTCT) and antiretroviral therapy (ARV) are now available. Eighty-two VCCT, 162 PMTCT, 81 ART centres have been established. The main challenges to the scale-up of HIV/AIDS interventions include poor access to key services for prevention, diagnosis and care, low uptake of the PMTCT and ART services, poor laboratory capacity at various levels, stigma, and discrimination against people living with HIV/AIDS (PLWHAs). Paediatric AIDS diagnosis and treatment also remains a major challenge.

2.2.3 Tuberculosis and Leprosy Burden

The burden of tuberculosis is increasing in Sierra Leone. As seen in Table 2, between 2004 and 2007, the number of registered TB cases in the country almost doubled, in spite of a case detection rate of about 50% (the WHO target is 75%). This is further complicated by the recent emergence of multi-drug resistant tuberculosis (MDR-TB). The TB/HIV co-infection is also an issue of concern: the prevalence of rate TB/HIV co-infection is 11.6%. However, the defaulter rate has been declining and the treatment success rate has increased, from 83% in 2004 to 87% in 2007.

Table 2: Tuberculosis trend in Sierra Leone

Year	2004	2005	2006	2007
Registered cases	5,863	6,930	8,208	9,623
Defaulter rate (%)	8.9	8.9	5.8	5.8
Treatment success rate (%)	83	85	85	87.1
Case detection rate (%)	42	46.7	45	52.1

Source: Annual report of national leprosy and TB control programme

Sierra Leone adopted the DOTS strategy in 1992. The number of DOTS centres has been increased to 80 nationwide. In 2006, the notification rate of new smear positive cases was 88.5/100 000. Outcome of treatment for new smear positive cases registered 9-12 months earlier showed a treatment success rate of 85%. However, the TB control programme is faced with issues of low case detection rates, high proportion of patients without sputum results, and high default rates.

Leprosy remains a disease of public health importance in Sierra Leone. The German Leprosy and Tuberculosis Relief Association (GLRA) estimates that the prevalence rate of leprosy in the country is about 0.80 per 10,000 people, although some districts have more than 2 cases per 10,000 people[7]. Multiple Drug Therapy (MDT) has been successfully implemented since 1983. About 526 cases were registered in 2005 and 549 cases were registered in 2006. Sierra Leone adopted the DOTS strategy in 1992. The treatment completion rates are now relatively high; between 2004 and 2007, the treatment completion rates increased marginally for both Pauci-bacilliary and Multi-bacillary cases of leprosy.

[7] German Leprosy and Tuberculosis Relief Association (GLRA) Report, 2006.

In response to the leprosy burden, the MOHS launched the National Leprosy Control Programme in 1973, and in 1990, the programme was integrated with TB control and became the National Leprosy and Tuberculosis Control Programme (NLTCP), which endorses the objectives set by WHO.

The main thrusts of the NLTCP are the integration of TB and leprosy services into the PHC systems and the reduction of TB and leprosy burden by effective diagnosis and treatment, until the diseases cease to be public health problems. The MOHS, in collaboration with WHO and other partners, has developed the NLTCP Strategic Plan for 2007–2011, whose main focus includes the expansion of DOTS implementation and MDT services, drug supply for anti-TB and anti-leprosy drugs, strengthening surveillance, M&E for MDR-TB, as well laboratory networks and services and operational research for TB and leprosy control.

2.2.4 Neglected Tropical Diseases

Neglected tropical diseases remain a major concern in Sierra Leone. The rapidity with which they can cause deaths and the possibility of becoming widespread over the years, make them diseases of major concern. Because of the neglect, reliable data on the incidence and mortality from these diseases are scarce. Soil transmitted helminths, onchocerciasis, lymphatic filariasis and yaws are the most important but neglected tropical diseases in Sierra Leone.

(a) **Soil transmitted helminthes.** The scale of infection with intestinal helminthiasis is enormous. People infected not only suffer illness but also reduction in physical vigour and impaired intellectual development. They will eventually be unable to work and their quality of life will deteriorate; signs and symptoms may vary according to the type of worm.

WHO has shown commitment and financial support by providing funding and technical support through a consultant for a pilot survey on mapping of the types of worm in the districts.

(b) **Onchocerciasis (river blindness) and lymphatic filariasis.** All districts in Sierra Leone are endemic for lymphatic filariasis (LF). The control of LF was integrated into the Onchocerciasis Control Programme in 2006, and by the end of 2007, a total of 6,380 community drug distributors (CDDs) had been trained to administer drugs for both onchocerciasis and LF. All 12 oncho-endemic districts, which include six border LF districts, continued mass drug administration. About 1,627,493 people were treated (therapeutic coverage of 74.3%), in 8,324 villages (geographic coverage of 98.5%).

(c) **Dracunculiasis (guinea worm disease).** Eradication status was granted to Sierra Leone by WHO in 2007 and active surveillance was to be conducted for the next three years. There has been no case detected since 2006. All suspected cases reported were incompatible with dracunculiasis on investigation.

(d) **Yaws.** Yaws has recently re-emerged as a significant disease in some districts of Northern Region, requiring public health intervention. There has been no survey done on yaws and no data available at this stage, but MoHS, in collaboration with WHO, is planning to conduct a survey in the known epidemic district of Bombali.

(e) **Schistosomiasis.** Schistosomiasis has become an emerging disease in six districts of Kono, Koinadugu, Kenema, Kailahun, Bo and Tonkolili, according to the NTD survey conducted by the NTD Task Force in 2008. Using the WHO protocol and expanding the study to four more chiefdoms per district, the study confirmed that

schistosomiasis was of public health concern. WHO will support the NDT Task Force to scale up the study to the remaining six districts including Western Area, and utilize this information to target the high prevalence areas in order to develop a plan of action for treatment of school-going children. The Ministry of Agriculture, Forestry and Food Security is also mapping out the areas infested by schistosomiasis as part of occupation hazard prevention for their workers in the rice swamp farms.

2.2.5 Disease Surveillance and Epidemic Alert and Emergency Response

In 2004, Sierra Leone adopted the Integrated Disease Surveillance and Response (IDSR) as a strategy to streamline and improve data collection, reporting and analysis from previously disparate disease reporting systems in the country. The current disease surveillance system is integrated with the VPD surveillance systems. The list of priority communicable diseases was reviewed and increased to 22 in 2007 and training on IDSR was provided for DHMT members. In addition, an integrated maternal morbidity reduction and child survival tool was developed and introduced, capturing key indicators of all vertical programmes. However, the challenge remains in scaling up the IDSR, low capacity for data management and analysis, especially at district and health facility levels and inadequate feedback. In spite of the current focus on tackling the huge burden of communicable diseases in the country, it is vital to strengthen the implementation and effectiveness of the national disease surveillance and response strategy and the epidemic alert and emergency response capacity.

In Sierra Leone, there are two main diseases of serious epidemic potential that occurred in the past five years, namely Lassa fever and Yellow fever.

(a) **Lassa fever.** A Mano River Union (MRU) Lassa fever control conference (between Sierra Leone, Guinea and Liberia) was convened in 2004 by WHO, with support from USAID and others. The MRU laboratory network has since been established and a new laboratory added to the Kenema Government Hospital to enhance case detection and management. There are indications that Lassa fever has become endemic in some districts. A 12-month European Union (EU) funded project for the establishment of community-based surveillance project is currently being implemented.

(b) **Yellow fever.** Routine yellow fever (YF) vaccination coverage was introduced in 2002 and coverage improved from about 60% in 2003 to more than 80% in 2006. However, YF coverage in 2007 was about 79%. The YF surveillance is being intensified and the country is earmarked for preventive mass campaign in 2009. Although no outbreak of yellow fever has been recorded since 2003, the disease continues to be a public health concern in the country because of the potential for yellow fever outbreaks.

(c) **Diarrhoeal diseases:** Diarrhoeal diseases, mainly cholera and dysentery from Shigella dysenteriae, pose a major problem in the country.

(d) **Emergency preparedness and response.** All countries are at risk of emergencies, disasters or crises. Many countries in the West African sub-region are at increased public health risks associated with emergencies, disasters or crises. Crises and disasters, whether natural or man-made, have devastating effects on health systems and infrastructure. Disabled and elderly people and patients of chronic illnesses are at greatest risk. Children and women are also the most vulnerable. Currently, the national authorities, with support from WHO and other partners, are developing a National Contingency Plan on Health that addresses natural and man-made disasters and disease outbreaks. Efforts are also being made to conduct a

humanitarian context analysis that will lead to the development of projects on emergencies as part of the contingency plan and strengthening the capacity of the disease prevention and control division for rapid response to emergencies. WHO supports the national authorities in health coordination; rapid health assessment; provision of essential drugs and supplies; training and supervision of health personnel; and development and review of contingency plans with changing situations. WHO also strengthens the capacity of the Disaster Management Department of the Office of the National Security for coordination of emergency preparedness and response.

2.3 BURDEN OF CHILDHOOD AND MATERNAL ILLNESSES

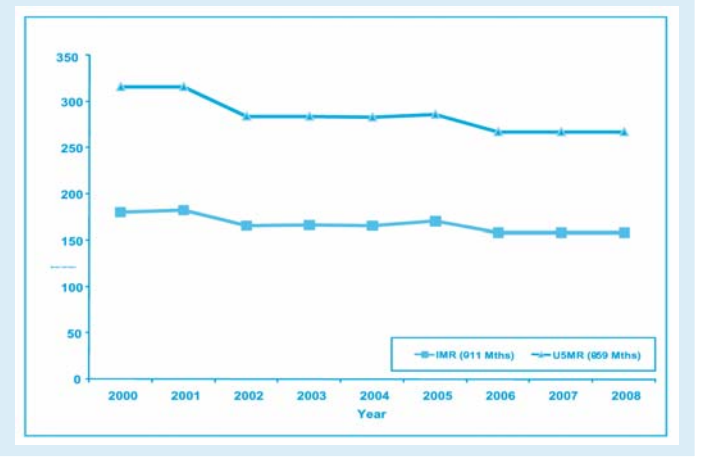
Reducing the burden of maternal and under-five illnesses and deaths is vital to the socioeconomic and health development of Sierra Leone. The country has the highest under-five mortality rate in the world, and one of the highest maternal mortality ratios (MMR) in the African Region.

2.3.1 Child and Adolescent Health

Sierra Leone is ranked as having the highest under-five mortality rate in the world, with almost one out of every three children dying before reaching the age of five[8] (See Table 3). The trend has not changed significantly in the past eight years (see Fig. 2). The three main causes of under-five mortality are malaria, diarrhoea and pneumonia and they account for over a quarter of all childhood deaths. Malnutrition plays a significant role, as 57% of the deaths would not have occurred if the children were not malnourished[9]. Neonatal death accounts for 20% of the overall under-five mortality rate, an indication of poor quality care during labour, delivery, and immediate postnatal period[10].

Adolescents (aged 10-19 years) constitute about 20% of the population, and many of them reach adulthood with little knowledge about reproductive health. The majority of youths

Figure 2: Trend of Infant and Under-5 year Mortality Rates in Sierra Leone, 2000 - 2008



[1] Sierra Leone Multiple Indicator Cluster Survey (MICS 3) 2005.
[2] Child survival situation analysis 2006.
[3] Opportunities for Africa 's newborns, PMNCH,2006.

(aged between 10 and 25 years) have no correct knowledge about sexually-transmitted infections, including HIV/AIDS, and risky sexual behaviour is common among them. In 2004, the net primary school attendance rate was 48%, the net secondary school attendance rate was 19% and the rate of marriage before the age of 15 was 27%, that is, almost one in every three girls. Health services do not adequately address the needs of adolescents in a comprehensive approach.

With the support of partners, the Ministry of Health and Sanitation has developed a Reproductive and Child Health (RCH) Policy (2008-2015). A RCH strategic plan for the period 2008-2010 has also been developed. A challenge to be met is coordinating the inputs of government and partners in mobilizing enough resources to ensure full implementation of the strategy. In addition, although breastfeeding is practised widely, there is a need to promote the initiation of early and exclusive breastfeeding. Guidelines on breastfeeding, and infant and child feeding are available.

2.3.2 Maternal Health

Apart from the high child mortality rate, Sierra Leone has one of the highest maternal mortality rates in the world with a maternal mortality ratio of about 495/100 000 births (see Table 3). The leading causes of maternal deaths are obstructed labour, haemorrhage, anaemia, sepsis and toxaemia in pregnancy, most of which are largely preventable and amenable to simple interventions. Inadequate maternal health services at and around birth are one of the contributing factors to the high maternal mortality, along with other health system weaknesses.

Table 3: Key Health and Development Indicators

Indicator	Value
Infant mortality rate (per 1000 live births) (2004)	158
Under-five mortality rate (per 1000 live births) (2004)	267
Births attended by skilled health personnel (%) (2004)	43
Maternal mortality ratio (per 100,000 live births) (2004)	495

Source: Census 2004, SL: Multiple Indicators Cluster Survey (MICS-3) 2005

Though 81% of pregnant women attended antenatal care in 2004, only 43% of births were institutional deliveries.[11] Many of the institutional deliveries were attended by MCH aides and assessments in 2004 and 2008 indicate that they lack the competencies to qualify as skilled attendants. Rates of contraceptive prevalence and exclusive breastfeeding for the first six months are low: 5% and 8% respectively. There is no data on postnatal care. There is a draft maternal and child roadmap which includes newborn care and continuum of care. However, improving women's access to quality health services and addressing the underlying socio-cultural factors are major challenges.

2.3.3 Immunization and Vaccine-Preventable Diseases

The target of the routine immunization programme in Sierra Leone, in alignment with the African regional IVD strategic plan, is to obtain a 90% immunization coverage rate at

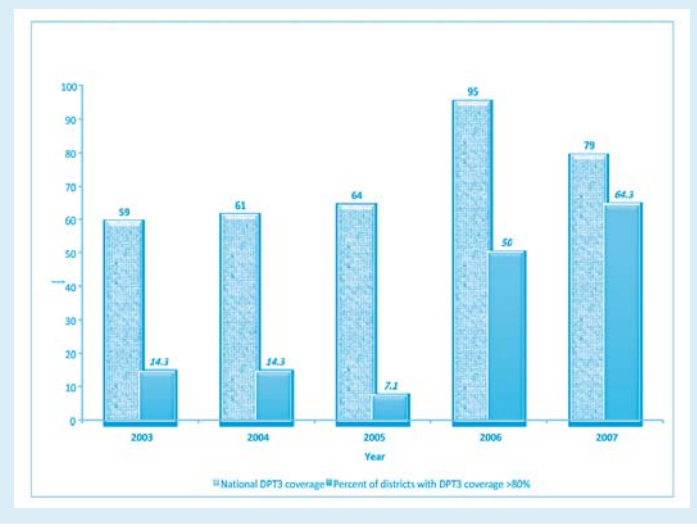
[11]Multiple Indicator Cluster Survey (MICS 3) 2005.

national level and 80% in at least 80% of districts ("90/80" target). Figure 3 shows that between 2002 and 2007, national DPT3 coverage increased from 59% to 79% and the percentage of districts with 80% DPT3 coverage increased from 14% to 64% in 2007.

However, the measles burden in Sierra Leone has dropped considerably because of the catch-up vaccination campaign conducted in 2003 and the follow-up campaign in 2006. Deaths from measles are currently near zero: in 2007, only 33 suspected cases were reported but none was confirmed to be measles.

A case-based surveillance system for measles and acute flaccid paralysis was developed as part of the integrated surveillance and response (IDSR) system. The last case of wild poliovirus was confirmed in 1999. With the support of partners, polio campaigns and AFP surveillance systems were put in place. Sierra Leone was granted provisional polio free status in 2007. The Sierra Leone EPI policy was formulated in 2002.

Figure 3: Trend of DPT3 and Districts achieving 80% coverage, 2003-2007



Specific interventions made to improve the national immunization system over the years include a data quality audit (DQA) in 2004 with a verification factor of 98%, EPI desk review in 2005, orientation to reach every district (RED) approach for DHMT members in all districts and assessment of the implementation of RED approach in July 2007. Others are vaccine management assessment in 2007, EPI mid-level management (MLM) international training for four senior national EPI staff members, and the introduction of the Pentavalent vaccine in 2007, aimed at enhancing protection of children from diseases such as hemophilus influenzae type B and hepatitis B infections. The support of GAVI for new vaccines and health system strengthening until 2015 is about US$ 20 million[12]. All these interventions have resulted in steady improvement in immunization coverage over the years (See Table 3). However, the challenge is to scale up and improve the quality of the Reach Every District (RED) approach in order to reach the "90/80" target and prevent vaccine-preventable diseases. There is also a need to integrate other maternal and child survival interventions into immunization services.

[12] GAVI Policy Development and Support to Sierra Leone, 2008.

2.4 NO34NCOMMUNICABLE DISEASES, INCLUDING MENTAL HEALTH

Noncommunicable diseases (NCDs) and conditions represent a significant burden in Sierra Leone. However, there is a dearth of up-to-date information on the prevalence of noncommunicable diseases such as hypertension and other cardiovascular diseases, diabetes mellitus and sickle-cell disease. In general, shifting the conventional mode of addressing NCDs from the tertiary care level to primary care and with a focus on risk reduction is a necessary but difficult approach for the prevention and control of NCDs. An isolated study conducted in 1994 revealed that about a quarter of the whole population in Freetown and over half of people aged 50 and above were hypertensive. A pilot study on sickle-cell disease in Freetown in the early 1990s indicated a prevalence of 23.8%. This suggests that, in addition to the rapidly rising infectious diseases, there is an epidemic of noncommunicable diseases. Mental health and substance abuse, disability, injuries, malnutrition and micronutrient deficiency represent a significant burden to the health and people of the country.

(a) **Mental health and substance abuse:** The country has a huge substance abuse problem. About 90% of admissions to the Sierra Leone psychiatric hospital are due to drug-related illnesses. A survey conducted in some communities and prisons in Sierra Leone revealed that 79% of the respondents used cannabis, 28% used cocaine, 26% used heroine and some used multiple drugs. The study further revealed that some children aged 7-8 years were also taking drugs[13]. Substances that are not under international control such as alcohol, tobacco, sedatives and hard drinks are also widely used.

A draft mental health policy has been developed. However, the capacity for effective implementation of the policy remains a challenge. Very few facilities exist for the management of mental health in Sierra Leone. In fact, the only major mental hospital (Sierra Leone Psychiatric Hospital) resumed operation only in 2006 and is currently functioning under very severe human resource constraints. It is staffed by one psychiatrist, two psychiatric nurses and some auxiliary nurses. Also, there are only three drug rehabilitation centres, with two located in Freetown and one in Kenema.

(b) **Tobacco control:** Sierra Leone has not ratified the Framework Convention on Tobacco Control (FCTC). A multi-disciplinary task force was set up in 2007 to advocate for the country's accession to this framework.

(c) **Disability and injury prevention:** The civil war left the country with over 7 000 amputees[14] who needed immediate physical rehabilitation and community reintegration. A national strategy on prosthetics and orthotics was developed. A draft national policy on disability has been developed and two districts are practising community-based rehabilitation as part of PHC. The major line ministries (MoHS and MoSWGCA) have instituted the National Disability forum where partners discuss disability issues and share best practices. Also, a national coordinating body was established and the MoHS is gradually taking over the responsibilities of the operation of the secretariat of this body. Major challenges in the area of disability management include the absence of a national database on disability and training of more districts on CBR and its integration into PHC.

[13] Assessment of the rends and patterns of drug abuse and drug-related HIV/AIDS situation in the communities and prisons of Sierra Leone(United Nations Office on Drugs and Crime).

[14] United Nations Consolidated Interagency Appeal for Sierra Leone, January-December, 2000.

(d) **Malnutrition and micronutrient deficiency**: Malnutrition plays a major role in infant and under-five morbidity and mortality. In a study carried out in 2007, the prevalence of underweight children under five years old was 24.8% compared to 31% in 2005[15]. On micronutrient deficiency, vitamin A has been included in the routine immunization schedule and periodic mass campaigns. A survey in 2003 revealed an iodine deficiency disorder (IDD) prevalence rate of 37% among 8–14 year olds[16]. Sensitization activities in the increased use of iodized salt are being conducted nationwide. The percentage of households that consume adequate iodized salt has increased as 45% now consume salt that is adequately iodized[17]. However, availability of iodized salt remains a challenge due to its relatively high cost in the local markets.

(e) **Environmental health:** The challenge of ensuring a regular supply of drinking water to the entire population (especially in the rural areas where the majority of the people live) remains a daunting one for the Ministry of Health and Sanitation. About 46% of households use improved sources of drinking water[18]. In spite of improving drinking water supplies, diarrheoal diseases remain a major cause of childhood mortality and sporadic cholera outbreaks occur annually.

Management of waste including clinical waste, solid waste and domestic and industrial wastewater is essential. Some 30.5% of households use sanitary means of excreta disposal. However, only a small proportion of wastewater receives any kind of treatment prior to its discharge. The management of clinical waste including sharp wastes in facilities and other places is also a challenge that needs to be addressed.

On food safety, the capacity to effectively monitor food manufacturers and suppliers to ensure the bacteriological and chemical safety of food as well as quality assurance is limited in Sierra Leone. Mass public awareness on food safety covering the gamut from "farm to fork" is required, and this will take considerable effort on the part of the authorities concerned.

2.5 HEALTH SYSTEM'S RESPONSE

In a bid to improve access to quality promotive, preventive, curative and rehabilitative services, the health system's response to the country's needs has improved over the years. However, meeting the entire gamut of health needs and expectations of the people, especially the poor and the disadvantaged, remains a daunting challenge. The response has mainly been in terms of policy reforms, management of health service delivery, human resource management and health financing, medicines and health technologies, information for health planning and management, and strengthening of partnerships for health.

(a) **National health policy and system reforms.** The national health policy, the road map for the health sector, is based on the principle of equity with particular attention to the most vulnerable groups. Twelve technical programme policies addressing most of the nine priority areas of health are being finalized. The priorities of Government as contained in these policy tools are shown in Box 1 below.

[15] Rapid Nutritional Status Assessment Survey, Sierra Leone, March 2007.
[16] Sierra Leone, National IDD Survey, Sierra Leone, March 2007.
[17] MICS, 2005.
[18] MICS 2005.

The management of health services is being restructured within the framework of a public sector reform that is supported by many development partners. Decentralization of health services commenced with the granting of autonomy to the districts. The hospitals operate under District Health Boards established through an Act of Parliament (2004). Hospital Management Committees exist in each district hospital chaired by the Medical Superintendent or Medical Officer in Charge.

In 2005, all primary health care (PHC) activities were devolved to local councils. As a result, government allocations for PHC activities are directly allocated to district councils through the Ministry of Local Government. The local councils in turn fund health activities proposed by the DHMT. Challenges of this devolved system include weakness in the organization, planning and management of the delivery of health care services within districts, weak linkages between national programmes and the district councils (which now control the resources for primary health services).

(b) **Management of service delivery**. The improving countrywide network of healthcare facilities has enhanced physical access to health services, particularly in respect of primary health care. On the health service delivery points, the ministry of health accounts for about 50% of health care services in Sierra Leone[1]. The other half is provided by NGOs and the private sector including faith-based organizations, the private-for-profit institutions and the traditional healers. The distribution of these facilities is however skewed to the urban areas; for example, seven of the nine tertiary care facilities and more than half of the 23 secondary care institutions are concentrated in the Western Area, mainly Freetown. A network of 927 functional peripheral health units (PHUs) exists; however, the weak referral system between PHUs and the secondary and tertiary health care levels is one of the drivers of high maternal and child mortality.

(c) **Human resource management.** A major concern of the government has been the human resource crisis, especially for health service provision in Sierra Leone. The adult literacy rate was only 25% in 2002-2003 and many qualified personnel that were displaced during the war are yet to return. In 2006, with support from key partners, the MoHS formulated a human resource policy whose vision is that, by 2015, the MoHS shall have in place adequate, well-managed, efficient and motivated human resources for health and sanitation capable of providing equitable access and services for a healthy and productive Sierra Leone. A Human Resource Strategic Plan, 2004-2008 is also in place.

However, the health sector continues to be faced with increasingly inadequate human resources, poor skills mix, demotivated workforce and a high attrition rate, exacerbated by the exodus of health workers[20]. The shortfalls in the number of required health manpower of various cadres in 2006 ranged from 23% to 81%, and this continues to constitute a major constraint in the development of health care delivery services in Sierra Leone. In order to meet the shortfalls, the Ministry of Education, Science and Technology (MEST), in collaboration with the University of Sierra Leone, the Ministry of Health and Sanitation and some nongovernmental organizations, has continued to provide training in local health training institutions. However, the intakes are very limited and the dropout rate is about 30%.

[19] NHA report 2004-2006.
[20] Human Resources for Health Policy in Sierra Leone for the Ministry of Health and Sanitation, February, 2006.

Box 1: Government of Sierra Leone Health Sector Priorities

Sierra Leone Vision 2025	Poverty Reduction Strategy Pillars (Promoting Human Development)	Sierra Leone MoHS Medium-term Rolling Plan (2008 – 2010)

• A high quality of life for all.
• A well-educated and enlightened society.
• Competitive, private sector-led economy with effective indigenous participation.
• A tolerant, stable, secure and well-managed democratic society.
• Sustainable, effective exploitation of natural resources in a quality environment; and.
• A science and technology-driven nation.
	• **Major Objective**
	  • Reduce under-five and maternal mortality rates.
	• **Expected Outputs:**
	  • Fully functional PHC units established.
	  • Under-five and maternal mortality rates reduced.
	  • Diagnostic and treatment facilities improved§ Increased access to clean water and sanitation.
		• To improve the delivery and quality of health care.
		• To reduce maternal, infant and under-five morbidity and mortality.
		• To increase accessibility and affordability of health services to a greater percentage of the population.
		• To reduce morbidity and mortality due to malaria and other communicable diseases.
		• To reduce the incidence of HIV/AIDS and other sexually-transmitted diseases.
		• To reduce malnutrition, especially among women and children.

(d) **Healthcare financing.** Although expenditure on health as a percentage of GDP has increased over the years, from 4.3% in 2000 to 7% in 2006, a high proportion (about 70%) of total health expenditure in Sierra Leone is out-of-pocket spending[21]. The major mode of financing the public health sector has been through budget allocation currently strengthened with HIPC funding and budgetary support from DFID, EU and ADB. The challenge here is to adopt a health sector financing policy and strategy that will be both equitable and pro-poor.

(e) **Medicines and health technologies**

(i) **Essential drugs quality and control.** To ensure that safe and efficacious drugs are available when needed, Sierra Leone has a drug policy and pharmaceutical control board. There is a functioning WHO level II pharmaceutical quality control laboratory, with very wide capacity to meet the current challenges for quality assurance of the medicines market. A national essential medicines list and standard treatment guidelines have been developed and in use to address

[21] Sierra Leone National Health Account Report 2004-2006.

the above problems. Health staff at district level have been trained on rational use of drugs. However, problems experienced in the pharmaceutical sector include poor storage facilities at district hospitals, weak management of medicines at all levels (lack of proper inventory, wastage due to non-use until expiry), importation of fake and sub-standard drugs, and smuggling of pharmaceuticals into the country and irrational use of medicines.

Other challenges include uncoordinated procurement of medicines and supplies by different partners, inadequate capacity in the MoHS to provide proper oversight, weak supply chain management and under- resourced capacity of the Central Medical Stores and the Pharmacy Board Quality Control Laboratory for quality control analysis of pharmaceuticals. Additionally, there is shortage of qualified pharmaceutical staff in the public sector, inadequate transport system slowing distribution of pharmaceuticals and medicines supplies, weak logistics management information system and weak capacity to forecast and quantify needs.

(ii) **Blood transfusion services.** A national blood transfusion policy and a blood transfusion service are in place. In 2007, WHO supported the development of a national blood transfusion strategic plan. Most of the laboratory assistants and technicians have been trained on blood quality management system and standard operating procedures (SOPs) developed. Implementation of the blood transfusion strategic plan is challenged by lack of resources. Only four districts (Western Area, Bo, Kenema, Makeni and Moyamba) have functional blood transfusion services. The major reasons for the limited coverage include erratic electricity power supply, lack of equipment, supplies and reagents, and a poorly organized system for blood collection, storage and distribution. In addition, weak systems for monitoring and supervision, inadequately trained personnel and weak strategies to mobilize voluntary blood donors remain major challenges.

(iii) **Medical equipment and supplies.** In the majority of the health facilities, medical equipment and supplies are inadequate or obsolete. Prominent amongst these are surgical and obstetric equipment, sterilizers (autoclaves), operating tables, theatre lights and suction pumps. National donation guidelines have been developed, which has standardized all health technology donations to the country. However, effective use of available equipment remains a major challenge due to lack of qualified personnel and poor electric power supply in many health facilities.

(iv) **Laboratories.** Sierra Leone does not have a functioning national public health laboratory or a network of laboratories at the peripheral level. Lack of equipment and reagents limits currently available services to routine and few specialized laboratory tests. Also limited is the laboratory capability to support the surveillance of diseases, particularly yellow fever and measles. A Lassa fever laboratory has been established in Kenema Government Hospital with support from WHO and other partner agencies. A few private laboratories and other diagnostic services exist, mainly associated with some private clinics, which grant growing contribution and complementarities to services provided by the public health sector.

(f) **Information for health planning and management.** In order to ensure adequate use of available health sector information for action, the health management information system is being strengthened. However, there is currently no national legislation or policy concerning health and management information. There are also severe shortages in the area of infrastructure, equipment and

workforce. The data generated is often not analyzed or used and there is no established system of feedback. However, WHO and the Health Metrics Network (HMN) are currently also supporting the strengthening of the HMIS, including the development of an integrated data warehouse (IDW).

In summary, Sierra Leone is striving towards a better future for its people by focusing on controlling a complex mix of health problems through improvement of health infrastructure, reduction of inequity and urban- rural differences, and by fostering partnerships among relevant stakeholders. However, major health development challenges in the health sector remain (see Box 2 below). The WHO country office will be reprofiled to harness the competencies and skill mix needed to implement the new CCS, by recruiting and/or expanding portfolio of the staff, where necessary.

Box 2: Principal health development challenges

- Reducing under-five and maternal deaths by accelerating access to high quality health services for children and mothers.
- Combating major communicable diseases, including malaria, HIV/AIDS and tuberculosis, and neglected tropical diseases.
- Containing the increasing trend of major NCDs, including drug abuse and mental illness and post-war disabilities, and reversing the trend by addressing the health risks.
- Ensuring equitable and sustainable access to safe water supply and sanitation, and promoting environmental and occupational health.
- Strengthening epidemic alert, and emergency preparedness and response to effectively tackle public health emergencies.
- Bolstering the health system's responsiveness for equitable access to quality health care, decentralization, human resource development and healthcare financing.
- Coordinating the alignment and harmonization of development partners' contribution and support to the health Sector.

SECTION 3

DEVELOPMENT COOPERATION AND PARTNERSHIPS

WHO is supporting the government within an environment of many development partners (DPs) with different types of funding mechanisms for health development. In addition, national and international NGOs are contributing significantly to the development of health in the country.

3.1 DEVELOPMENT COOPERATION

Assistance from development partners over the last decade has consistently been a significant part of the health sector expenditure. Financial contribution from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the GAVI Alliance constitutes an important component of aid flow to Sierra Leone. GFATM funds are channelled through the government and NGOs, whereas GAVI funds are allocated only to the government. Major contributors to development assistance funds for health and their areas of support are shown in Table 4.

Table 4: Financial Support US$ from Health Partners 2004/05 - 2006/07

1. Multilateral Agencies							
EU	Rehabilitation, management and capacity building. PHC (HLRRD)	500	750	28,000	1,500	4,619.8	461,733.9
World Bank	Primary and secondary health care, Rehabilitation, child survival	15,000	10,000	20,000	7,627.1	8,666.2	
ADB	Pharmaceutical sector, Rehabilitation	1,300	1,300	900	2,231.8	612.4	
	Health services management			138.3	138.3	138,.3	138.3
IDB	Rehabilitation, capacity building			15,000	139.13		
UNICEF	Primary health care, immunization	25,000	2,700	6,000	6,293.5	7,798.8	
UNFPA	Reproductive health	1,750	2,400	8,000	4,400		
UNDP	Procurement of supplies			15,000			
FAO	Supplementary feeding	2,500	1,500	3,500			
2. Bilateral Agencies							
Ireland	Emergency Obstetrics				342	720	720
DFID	Health				7,980	8,600,2	4,157.9

3.2 COORDINATION, HARMONIZATION AND ALIGNMENT OF PARTNERS

Many development partners and donors support the health sector in Sierra Leone. In addition to WHO, the main partners working in health include UN agencies (UNICEF, UNFPA, UNDP, FAO and WFP), the World Bank, EU, DFID, Irish Aid and the ADB. The major development partners and their areas of support are shown in Table 5 below.

Table 5: Development partners' priorities

Areas of Support	Development Partners
General Management (excluding HR)	WHO, Irish AID, World Bank, GLB Fund, EU
Decentralization	WHO, Irish AID, World Bank, DFID, EU, UNICEF
Monitoring and Evaluation	WHO, UNICEF Irish AID, World Bank, EU
Medical Waste Management	WHO, World Bank, UNICEF
Human Resources (Also includes short-term trainings)	WHO, Irish AID, UNICEF, USG, World Bank, EU, ADB, UNFPA
Curative Health Care	WHO, World Bank, USG, GLB Fund, MCC,UNICEF
Communicable Diseases	WHO, Irish AID, USG, GLB Fund, DFID,UNICEF
Noncommunicable Diseases	WHO, IDB
Disability Services	WHO, NORAD
Social Welfare Services	USG, GLB Fund, EU, UNICEF
Public Health Services	WHO, UNICEF, USG, GLB Fund, EU,

WHO is supporting efforts in the MoHS to strengthen government ownership and leadership in health sector issues, in line with the "Paris Declaration on Aid Effectiveness". With contributions from WHO, the MoHS has developed two sets of guidelines to support the coordination of partner interventions: (a) Guidelines for donors, agencies and organizations active in the health sector, developed in 1995[22]; and (b) Policy regulations on the operations of NGOs (2000)[23].

Harmonization of donor support and alignment with national plans and strategies is essential for aid effectiveness. A sector-wide approach (SWAp) mechanism has been put in place to strengthen the alignment and harmonization of technical and financial support as well as foster mutual accountability of the government and partner organizations. Since 1996, the health sector has been making efforts towards a sector-wide approach. However, Sierra Leone's current SWAp status may be categorized as an Early SWAp. In this context, the MoHS has developed a sector programme with a three-year rolling plan, and will organize two coordination meetings per year - the first will focus on a sector review, whilst the second meeting will discuss broad planning, resource mobilization and allocation.

[22] Guidelines for donors, agencies and organizations active in the health sector in Sierra Leone, Department of Health, Government of Sierra Leone, 1995.
[23] Policy regul ations on the operations of NGOs, Government of Sierra Leone, 2000.

The engagement of WHO with the SWAp mechanism, in accordance with WHO's guidelines[24], will involve dialogue, technical assistance, convening, capacity building, and seed funds for catalytic work or innovations, as agreed with the government in WHO workplans. WHO's internal financial management systems will be used for all these activities. Where WHO has entered into a specific agreement with a donor to act as a "pass through", or channel, for funds, then these may be included in a "pooling" arrangement.

Mechanisms for coordination in the health sector include the following:

(a) **Health Policy Advisory Committee**- chaired by the Minister of Health and Sanitation, its membership includes directors from the MOHS and representatives of WHO, UNICEF, UNFPA AND WFP.

(b) **Inter-Agency Coordinating Committee (ICC)**- oversees planning, resource mobilization and partnership for EPI activities.

(c) **Country Coordination Mechanism (CCM)**- oversees the implementation of projects financed through the GFATM and meets quarterly.

(d) **Health Development Partners Forum**- meets monthly to share information and enhance coordination of activities.

(e) **Development Partnership Aid Coordination Committee (DEPAC)**- comprises government ministers, bilateral and multilateral partners, and UN agencies; it monitors the flow of donor assistance and the implementation of agreed projects, including health, and is chaired by the Vice-President of the Republic of Sierra Leone; the vice-chairs are the World Bank and UNDP.

(f) **PRS Sectoral Task Force for Health**- reports to DEPAC; tracks and monitors HIPC resources allocated to the health sector.

The United Nations Development Assistance Framework (UNDAF), an umbrella programming mechanism of the UN Country Team in Sierra Leone, works in close cooperation with and has aligned its priorities to that of the government. The UNDAF priorities are shown in Box 3 below.

Box 3: Sierra Leone United Nations Development Assistance Framework (Health Programme-related Outcomes), 2008 – 2010

UNDAF Priority Area: Maternal and Child Health
UNDAF Outcome 3: Improved health for children under five and women of child-bearing age with emphasis on reduction in child and maternal mortality rates
UNDAF Priority Area: HIV/AIDS, Malaria and Tuberculosis
UNDAF Outcome 5: By 2010, the national response to HIV/AIDS is strengthened through increased access to prevention, treatment, care and support services and reduction of stigma and discrimination.

Coordination mechanisms within the UN Country Team are as follows:

(a) **Heads of Agencies Meeting**- meets weekly to coordinate the implementation of activities, including health. The UNDAF forms the basis for joint assessment, planning and collaboration of agency activities.

(b) **UN Theme Group for HIV/AIDS**- meets monthly; has an annual rotational chairmanship between the World Bank and UN agencies.

[24] WHO (2006). A guide to WHO 's role in sector-wide approaches to health development; CCO/06.1

(c) **Youth Theme Group**- recently instituted to address crosscutting youth issues, including health and prevention of HIV/AIDS and STIs.

(d) **Gender Theme Group**- addresses gender-related issues, including gender-based violence, sexual exploitation and abuse and other health problems.

While the development community and donors remain committed to supporting the health sector, the need for improvements in the coordination and follow-up of activities planned by different role players remains a challenge.

SECTION 4

PAST AND CURRENT WHO COOPERATION

WHO has been undergoing significant changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges, and achieve the health-related MDGs. This organizational change process has, as its broad frame, the WHO Corporate Strategy.

4.1 GOAL AND MISSION

The mission of WHO remains "the attainment by all peoples, of the highest possible level of health" (Article 1 of WHO Constitution). WHO's global and the African regional directions are encapsulated in the WHO Corporate Strategy, the Eleventh General Programme of Work 2006-2015, the Medium Term Strategic Plan (MTSP) and the Strategic orientations for WHO action in the African Region 2005-2009 which outline key features through which WHO intends to make the greatest possible contribution to health. The Organization aims at strengthening its technical and policy leadership in health matters, as well as its management capacity to address the needs of Member States, including the Millennium Development Goals (MDGs).

4.2 CORE FUNCTIONS

The work of the WHO is guided by its core functions, which are based on its comparative advantage. These are:

(i) Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.

(ii) Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.

(iii) Setting norms and standards and promoting and monitoring their implementation.

(iv) Articulating ethical and evidence-based policy options.

(v) Providing technical support, catalyzing change, and building sustainable institutional capacity.

(vi) Monitoring the health situation and assessing health trends.

4.3 GLOBAL HEALTH AGENDA

In order to address health-related policy gaps in social justice, responsibility, implementation and knowledge, the global health agenda identifies seven priority areas. These include:

(a) Investing in health to reduce poverty;

(b) Building individual and global health security;

(c) Promoting universal coverage, gender equality, and health-related human rights;

(d) Tackling the determinants of health;

(e) Strengthening health systems and equitable access;

(f) Harnessing knowledge, science and technology;

(g) Strengthening governance, leadership and accountability.

In addition, the Director-General of WHO has proposed a six-point agenda: 1. Health Development; 2. Health Security; 3. Health Systems; 4. Evidence for Strategies; 5. Partnerships, and 6. Improving the performance of WHO. The Director-General has, in addition, indicated that the success of the Organization should be measured in terms of results on the health of women and the African population.

4.4 GLOBAL PRIORITY AREAS

The global priority areas have been outlined in the Eleventh General Programme of Work. They include:

(i) Providing support to countries in moving to universal coverage with effective public health interventions;

(ii) Strengthening global health security;

(iii) Generating and sustaining action across sectors to modify the behavioural, social, economic, and environmental determinants of health;

(iv) Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;

(v) Strengthening WHO's leadership at global and regional levels and supporting the work of governance at country level.

4.5 REGIONAL PRIORITY AREAS

The African regional priorities have taken into account, the global documents and the resolutions of the WHO governing bodies, the health-related Millennium Development Goals, and the NEPAD health strategy, resolutions on health adopted by heads of state of the African Union and the organizational strategic objectives which are outlined in the Medium Term Strategic Plan (MTSP) 2008-2013. These regional priorities have been expressed in the "Strategic orientations for WHO action in the African Region 2005-2009". They include prevention and control of communicable and noncommunicable diseases, child survival and maternal health, emergency and humanitarian action, health promotion, and policy making for health in development and other determinants of health. Other objectives cover health and environment, food safety and nutrition, health systems (policy, service delivery, financing, technologies and laboratories), governance and partnerships, and management and infrastructures.

In addition to the priorities mentioned above, the Region is committed to supporting countries attain the health MDG goals, and tackle their human resource challenges. In collaboration with other agencies, the problem of how to assist countries source financing to attain their goals will be addressed under the leadership of the countries. To meet these added challenges, one of the important priorities of the Region is that of decentralization and establishment of Intercountry Support Teams to further support countries in their own decentralization process, so that communities may benefit maximally from the technical support provided to them.

To effectively address the priorities, the Region is guided by the following strategic orientations:

(a) Strengthening WHO country offices;
(b) Improving and expanding partnerships for health;
(c) Supporting the planning and management of district health systems;
(d) Promoting the scaling up of essential health interventions related to priority health problems;
(e) Enhancing awareness and response to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT THE COUNTRY LEVEL

The outcome of the expression of WHO's cooperation strategy at country level will vary from country to country depending on the country's specific context and health challenges. Building on WHO's mandate and its comparative advantage, the six critical core functions of the Organization (outlined in section 1.2) are adjusted to suit each individual country's needs in line with the WHO Country Focus Policy which gears the operations of WHO to the needs of Member States at country level.

Current WHO Cooperation in Sierra Leone

WHO aims to provide leadership and foster partnerships in order to achieve effective and at-scale impacts. The essential focus of WHO's work is on provide technical support for health development, with particular emphasis on its normative role and the promotion of skills development. These interventions are elaborated more specifically as "WHO's core functions" (Section 4.2 – WHO policy framework: Global and regional directions). In order to ensure harmonization of WHO work with partners having a common goal, the approach adopted by WHO is to constantly seek opportunities for partnership. This is reflected in the frequent joint programming with government departments, other UN agencies and NGOs. The WHO Cooperation Strategy (2004-2007) was aligned with Sierra Leone's national health policy (revised in 2002) and the focus of the partner agencies. The strategic agenda comprised six principal components, as shown in Box 4 below.

Box 4: WHO/Sierra Leone CCS 2004-7 Strategic Agenda

Component 1: Health transition from emergency to recovery and development

- Contribution to improve access to healthcare in areas with high concentration of resettling internally- displaced persons (IDPs) and returnees.
- Support to GoSL to reach the underserved population with healthcare.
- Support to establish an emergency and epidemic preparedness and response unit at central level and focal points at district level.
- Support the development of a crash training programme for basic health personnel needed to address the immediate needs of the health sector in rural areas.

Component 2: Rehabilitation of the health system

- Health and management information system; Development of human resources for health.
- Health systems research; Health care financing in sustainable development.
- Health sector reform capacity building.
- Health technology, including Safe blood transfusion, medicines and medical supplies and laboratory services.

Component 3: Disease prevention and control

- Diseases of poverty - HIV/AIDS, tuberculosis and malaria.
- Epidemic diseases – cholera, meningitis, yellow fever and Lassa fever.
- Neglected tropical diseases - guinea worm, leprosy, lymphatic filariasis, onchocerciasis and schistosomiasis.
- Noncommunicable diseases - mental health and other noncommunicable diseases (cardiovascular diseases; diabetes mellitus; cancers, oral health).

Component 4: Health promotion

- Health promotion and protection.
- Nutrition.
- Disability and injury prevention.
- Health and environment.

Component 5: Reproductive, child and adolescent health

- Sexual and reproductive health; Making pregnancy safer.
- Integrated Management of Childhood Illness (IMCI).
- Adolescent health; Gender-based violence.
- Expanded Programme on Immunization (EPI).

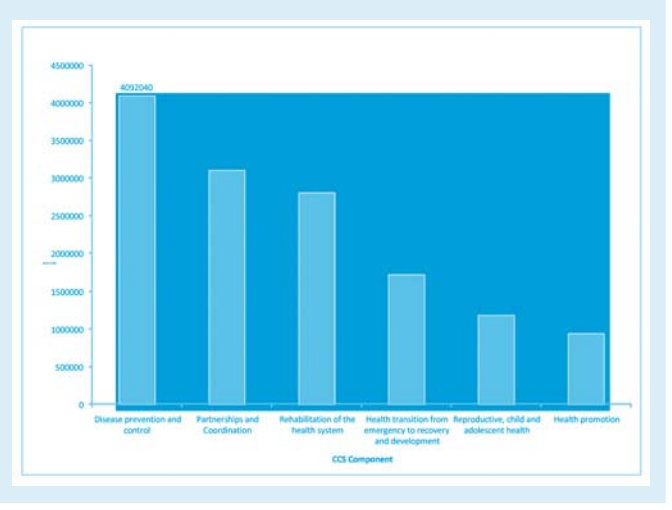
Component 6: Partnerships and coordination

- Development of partnerships - UN agencies, multilateral and bilateral agencies, international and national NGOs.
- Strengthening the coordination role of the Ministry of Health and Sanitation.
- Improved capacity of WHO staff.

4.7 CONTRIBUTIONS OF WHO COOPERATION STRATEGY 2004 - 2007

WHO support to Sierra Leone for the period 2004–2007, was US$13 830 280 as shown in Figure 4.

Figure 4: WHO CCS/Sierra Leone 2004-2007: Approved Budget



Disease prevention and control, and partnerships and coordination activities were allocated more than US$7 million in support of Malaria, Emergency humanitarian action and WHO presence in the country. About two thirds of the total expenditure during the period was in support of the major priorities of the MOHS, including Malaria control, Emergency humanitarian action, HIV/AIDS, Essential medicines - access, quality and rational use, WHO's presence in the country, and Immunization and Vaccines development. The major achievements in the six core areas of the CCS are outlined below:

COMPONENT 1- HEALTH TRANSITION FROM EMERGENCY TO RECOVERY AND DEVELOPMENT

WHO supported the rehabilitation and functioning of some PHUs and adaptation of tools for avian flu, and led the interagency assessment of flood-prone districts. In human resources for health, WHO's technical support was critical to the successful formulation of the HRH policy and plan. With WHO's support, the College of Medicine and other health training institutions were strengthened, which led to an increase in the number of trained and qualified health personnel. Some districts received technical support in human resource management. For injury prevention and disability, a draft policy and plan on disability was developed and district health workers were trained in CBR and some disabled persons' organizations were strengthened.

COMPONENT 2- REHABILITATION OF THE HEALTH SYSTEM

To strengthen health system policies and service delivery, WHO provided support to the MOHS to develop a national health policy and strategic plan. DHMTs were also supported to provide supportive supervision and monitoring on adherence to the use of health policy and guidelines at district level. Towards ensuring sustainable health financing and social

protection, a task force on national health accounts was trained on the methodology of developing national health accounts. National health accounts for the periods 2004, 2005 and 2006 were developed and reports were made and shared with all stakeholders.

Toward strengthening policy making for health in development, WHO supported the training of DHMTs in seven districts to conduct surveys using tools on the operationality of their district health systems and economic efficiency of their health facilities. The recommendations of these studies enabled DHMTs to enhance their planning, organization and implementation of the delivery of health services in their districts.

On essential health technologies, a national blood transfusion strategic plan was developed and health development partners are being sensitized to mobilize resources for the implementation of the plan, with the support of WHO, and a vehicle was provided to facilitate training, monitoring and supportive supervision of laboratory technicians at district level to ensure safe blood transfusion. WHO supported the training of nationals to develop second and third levels of SOPs and more than 50 laboratory technicians were trained on basic techniques in blood screening and transfusion.

To support the MoHS to ensure the accessibility, quality and rational use of essential medicines, WHO facilitated the revision of the national medicines policy and the sensitization of the public and private sectors. Two mini-laboratories were procured for the Sierra Leone Pharmacy Board, for use at border points of the country. The Pharmacy Board Act (2001) was also reviewed to reflect the new national medicines policy.

WHO supported the development, printing and distribution of the Sierra Leone Comprehensive Standard Treatment Guidelines. The medicines registration and inspection system was strengthened and ad hoc task forces of the Pharmacy Board at provincial level were supported to monitor the use of quality and safe medicines. On food safety, WHO supported the intensification of the supervision and monitoring of the use of food and hygiene norms and standards countrywide.

COMPONENT 3- DISEASE PREVENTION AND CONTROL

This component focused on the control of TB, HIV/AIDS, malaria and other tropical diseases, noncommunicable diseases, and disease surveillance. With WHO support, the DOTS strategy was expanded to cover the entire country and coordination between the National Leprosy and TB Control and National AIDS Control programmes was strengthened. Also, the technical support of WHO ensured that applications to the Global Drug Facility for adult and paediatric TB drugs were approved. It is noteworthy that TB treatment success rate has since improved. HIV/AIDS prevention, treatment, care and support services were strengthened, as was the capacity of staff on HIV/AIDS laboratory and HIV/AIDS medicines, through the technical and financial support of WHO. With WHO advocacy support, the HIV/AIDS bill was passed through Parliament.

With respect to malaria control, WHO supported the development of the national malaria control policy and strategic plan for malaria control (2004-2008). ACT policy was adopted and scaled up nationally. The capacity of health workers to adequately manage malaria cases within 24 hours of onset of fever was strengthened. With WHO support, ITN coverage was scaled up through the 2006 integrated measles and malaria campaign, integrated EPI and RH programmes and social mobilization. The intermittent preventive treatment of pregnant women attending ANC was also improved.

On epidemic alert and response, the capacity to implement the IDSR strategy was strengthened through trainings, including the capacity to respond to outbreaks.

On surveillance, prevention and management of noncommunicable diseases, WHO advocated for the designation of focal points for NCDs by the MOHS and trained them on the STEPWISE approach to surveillance of NCDs.

With WHO support, Sierra Leone was certified guinea worm free. Lymphatic filariasis control was initiated in six districts. A situation analysis was conducted for human African trypanosomiasis and technical, material and financial support was made available for the prevention, diagnosis and management of Lassa fever.

COMPONENT 4- HEALTH PROMOTION

WHO supported the MOHS in commemorating international health days such as TB, Leprosy, World Health Day, World No Tobacco Day, Mental Health, Diabetes and Hypertension and World AIDS Day. World Mental Health Days were also commemorated countrywide particularly in communities in the thirteen health districts, in order to strengthen awareness and support for mental health issues. Environmental health officers were trained on WHO initiatives such as the healthy settings initiative, and some communities were also sensitized on the healthy settings initiative.

On nutrition, WHO supported the development of a nutrition surveillance system, focused on reducing the infant and child mortality rate and combating malnutrition among children under five, particularly in displaced camps. Health staff were also trained at community level to prevent and control anaemia among children and pregnant women. The School Health Programme in districts was supported and preparation for the Global Youth Tobacco Survey initiated.

COMPONENT 5- REPRODUCTIVE, CHILD AND ADOLESCENT HEALTH

WHO supported the successful introduction of the pentavalent vaccine into routine immunization countrywide and the attainment of 80% coverage at national level. The successful implementation, with WHO technical and financial support, of the follow-up measles mass immunization campaign - integrated with ITN distribution and other childhood interventions - and the achievement of 100.4% measles administrative coverage, is noteworthy. Sierra Leone also achieved a polio-free status with the presentation to and acceptance by the African Regional Certification Commission (ARCC) of the country's polio-free certification document.

On child and adolescent health, the development of the Reproductive and Child Health Strategic Plan (2008 -2010) was a major milestone. This comprehensive integrated strategic plan outlines the reproductive and child health strategies and actions needed to ensure that Sierra Leone stays on course to achieve the Millennium Development Goals. The overall objective of the strategic plan is to reduce maternal, infant and under-five mortality rates by 30% of the 2005 values by 2010 by providing comprehensive, quality reproductive and child health services and strengthening the health systems. Imbedded in the RCH Strategic Plan, the child and adolescent health strategies consist of high impact, cost-effective interventions such as IMNCI, EPI, early and exclusive breastfeeding, and Vitamin A and other micronutrient supplementation. IMCI was included in the curricula of newly revised SECHN as Midwives curriculum, through the technical support of WHO. The school health programme in districts was supported and preparation for the Global Youth Tobacco Survey initiated. The national reproductive health policy was also revised and the integrated care of pregnant women and children (taking into account the continuum of care) was strengthened. WHO also supported capacity building in emergency obstetric and newborn care among health care personnel.

COMPONENT 6- PARTNERSHIPS AND COORDINATION

In order to strengthen the effectiveness of donor contributions, WHO supported the alignment and harmonization of donor inputs with MOHS priorities and strengthened the interagency coordination mechanisms. WHO's presence in countries - consisting of the physical presence of and integrated support from regional offices and HQ - was strengthened by ensuring a conducive work environment and strong collaboration with the IST, AFRO and HQ in rapidly responding to partners' needs for technical support.

4.8 RESPONSIVENESS OF THE CCS TO CHANGING PRIORITIES IN SIERRA LEONE

The CCS represents WHO's medium-term strategic priorities based on each country's needs. However, country priorities do change. WHO therefore has to undertake new initiatives because of changing priorities, in alignment with government and the UN Country Team. During 2004-2007, examples of changes that occurred include the emergence of avian flu and MDR-XDR-TB.

MDR-XDR-TB and avian flu fell within the existing priority areas; the response was therefore to provide the increased focus of funding and technical support required. Sierra Leone was not directly affected by the avian flu but it had to be prepared. WHO facilitated the development of the Sierra Leone National Avian Influenza Preparedness Plan, procurement of equipment and preparation for simulation exercises.

4.9 SUPPORT FROM WHO REGIONAL OFFICE AND WHO EADQUATERS

The WHO Regional Office for Africa and WHO headquarters provided significant technical support to the WHO country office in Sierra Leone. Both offices supported the participation of WHO staff as well as government officials in meetings of WHO governing bodies, technical and programme review meetings, joint missions to countries, production of advocacy and training materials, and increasing information exchange. The ability of the Regional Office and HQ to respond to some of the needs of Sierra Leone, sometimes at very short notice, is commendable.

4.10 IMPLEMENTATION CHALLENGES

Many of WHO's achievements in Sierra Leone may be attributed to its strong linkage with the MoHS. WHO is establishing itself as the principal source of credible, trusted and evidence-based advice on health matters. The ability of the WHO country office in Sierra Leone to build and maintain productive partnerships with other development partners like donor agencies is another key strength that has undoubtedly supported progress towards the achievement of national health goals. The technical expertise of the staff within the country office, coupled with prompt technical backstopping from the Regional Office, bolstered WHO's presence in the Sierra Leone.

However, weaknesses of the implementation of the current CCS include the weak documentation of WHO achievements and contributions. The partners' perception of WHO's performance and contributions needs to be improved. The skill mix of staff and competencies of the WCO team also needs to be broadened. In additions, limited funds sometimes resulted in a lack of bargaining power with bilateral and other UN organizations that have a strong physical presence in the country. These and other issues are outlined in the Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis table shown in Annex III.

SECTION 5

STRATEGIC AGENDA FOR WHO COOPERATION

In accordance with the WHO Constitution, the mission of WHO in Sierra Leone remains "the attainment by the people of Sierra Leone, of the highest possible level of health". The overarching principles of the Country Cooperation Strategy 2008-2013 are a commitment to primary health care (PHC), the human right to health and equity.

5.1 STRATEGIC PRIORITIES

Based on the analysis of health and development challenges, current WHO collaborative programmes, its comparative advantage, and a review of work of development partners, four *strategic priorities* have been identified. The strategic priorities fall within three WHO Organization-wide strategic domains: 1: Health Security; 2: Health System Capacities and Performance; and 3: Partnerships, Gender and Equity, as shown in Box 5.

Box 5: WHO Strategic Priorities 2008 - 2013

Strategic Domain	Strategic Priorities
A: Health Security	1: Reduce the health, social and economic burden of communicable and noncommunicable diseases
	2: Reduce infant, child and maternal morbidity and mortality, and promote responsible and healthy sexual and reproductive health behaviour
B: Health System Capacities and Performance	3: Strengthen health policies and systems to improve access and quality of services
C: Partnerships, Gender and Equity	4: Foster partnerships and coordination for national health development: Strengthen the control of Malaria, HIV/AIDS and Tuberculosis

The main elements of each strategic priority and the main focus and how each element will be implemented are elaborated below.

Domain 1: Health Security

Strategic priority 1: Reduce the health, social and economic burden of communicable and noncommunicable diseases

The prevention of communicable diseases is one of the most cost-effective public health interventions; it can also yield positive economic returns, particularly among the most marginalized and economically disadvantaged population groups. Prevention, control and surveillance of communicable diseases are all essential components in human security, including health security and economic development. Within this strategic priority, WHO aims to support the control of malaria, HIV and AIDS and tuberculosis. Support will also

focus on the elimination and eradication of vaccine-preventable diseases and strengthening of integrated disease surveillance, reduction of noncommunicable diseases as well as the promotion of healthy lifestyles and cost-effective interventions in Sierra Leone.

Main Focus:

The main focus of this strategic priority will be toward strengthening the prevention and control of malaria, combating HIV/AIDS and tuberculosis and enhancing the capacity of the national immunization programme for effective prevention and control of vaccine-preventable diseases. As a strategic approach, support for effective integrated disease surveillance, preparedness, response and control of communicable diseases, including the implementation of International Health Regulations and the prevention and reduction of noncommunicable conditions, as well as the promotion of health and development and prevention of important risk factors to health in Sierra Leone will be addressed.

1.1: Strengthen malaria prevention and control

As a major cause of illness and death in Sierra Leone, prevention and control of malaria will remain a major focus of WHO. Toward ensuring appropriate policy guidance and programme direction, WHO will support the in-depth review of the Malaria Strategic Plan 2004 – 2008 and the development of the second-generation Malaria Strategic Plan 2009 – 2013, in line with universal access recommendations. WHO will continue to support the scaling up of community-based interventions, including home management of malaria, nationally. The review of the essential medicines list in line with community-based interventions, will also be supported, as well as the updating of relevant implementation plans and guidelines at all levels.

To ensure effective monitoring and evaluation of progress, WHO will continue to provide support for routine, timely and complete reporting of malaria morbidity and mortality. Surveys, including Malaria Indicator Survey/Prevalence Surveys, Health Facility Surveys and Coverage Surveys, will remain important priorities for WHO. Support will also be provided for the documentation of best practices in malaria prevention and control and for research on community-based interventions, especially RDTs and ACTs at community level.

1.2: Combat HIV/AIDS and tuberculosis

In response to the increasing burden of HIV/AIDS and tuberculosis, which are recognized as major threats to the socio-economic development of Sierra Leone, WHO will further enhance support for the national scale-up toward universal access to TB and HIV/AIDS prevention, treatment, care and support interventions especially the diagnosis and treatment of paediatric AIDS. WHO will support the review of Sierra Leone's National HIV Strategic Plan 2006-2010 and the development of the National HIV Strategic Plan for 2011-2014. Support will be provided for the revision of antiretroviral treatment guidelines and development of HIV/AIDS operational plans. In addition, the procurement, supply and management (PSM) system for essential medicines and health commodities will be strengthened in order to enhance the availability of antiretroviral and anti-TB drugs. The capacity for laboratory testing for HIV will also be strengthened at national and sub-national levels.

WHO has a crucial role in supporting and coordinating surveillance of HIV/AIDS and tuberculosis, including the synthesis and dissemination of data for informing policy decisions and public health responses. WHO will continue its support to the MOHS toward monthly, quarterly and annual monitoring of progress as well as the annual sentinel, sero-prevalence surveys and behavioural surveillance surveys. The prevention of stigma and discrimination, and the greater involvement of people living with HIV/AIDS in the communities will receive

more focus. WHO will increase support for operational research into TB and HIV interventions.

With respect to strengthening tuberculosis and MDR-TB control, the expansion of the DOTS strategy will remain a major priority for WHO. Appropriate support will be provided for the revision of the national TB Strategic Plan 2008-2012, and development of national TB policy and relevant operational guidelines. Technical support and capacity building will be provided for TB laboratory capacity strengthening, including TB culture and drug susceptibility testing. In addition, WHO will work with MOHS and other stakeholders to strengthen the national capacity to monitor and evaluate TB trends and to document best practices and conduct relevant TB prevalence studies and other relevant operations research studies. WHO will continue to support the expansion of MDT services, and strengthen surveillance and M&E, and operational researches for leprosy control.

1.3: Enhance capacity of the national immunization programme for effective prevention and control of vaccine-preventable diseases

The control of vaccine-preventable diseases has proved remarkably successful in reducing inequities by reaching hard-to-reach marginalized, poor and young populations in Sierra Leone. The Global Immunization Vision and Strategy (GIVS) has articulated the approaches to protecting more people by making immunization available to all eligible people, introducing new vaccines and technologies, and linking immunization to the delivery of other health interventions and overall development of the health sector. In line with GIVS, policy and technical support will be provided toward strengthening the immunization programme in Sierra Leone.

During the period 2008-2013, WHO will support in-depth reviews of the immunization programme and the Sierra Leone EPI policy. WHO will continue to support the nationwide scale-up and strengthening of the Reach Every District (RED) approach and the integration of other maternal and child survival interventions into immunization services. Technical support will be provided for the in-depth review of the programme and updating of the comprehensive multi-year plan (cMYP) for Immunization. Support for the introduction of new cost-effective vaccines as well as the ongoing drive for effective measles control and maintenance of polio-free status will be enhanced.

Strengthening the integrated disease surveillance and response system will remain a major focus of WHO. In order to improve the quality of data generated, WHO will support data quality reviews, data quality self-assessments (DQS), programme assessments and coverage surveys. Support will also be provided to enhance the documentation of best practices and timely reporting of monthly, quarterly and annual performance trends in Sierra Leone. WHO support will continue toward building capacity at the district level for integrating immunization programme services and surveillance with other priority public health interventions.

1.4: Support for effective integrated disease surveillance, epidemic preparedness and response including the implementation of International Health Regulations and prevention and control of communicable diseases including neglected tropical diseases (NTD)

The prevention, control and surveillance of communicable diseases are all essential components in human security, including health security and economic development. WHO will continue its support for strengthening the integrated disease surveillance and response (IDSR) system, including effective utilization of existing field surveillance networks in the country.

To enhance emergency preparedness and response and the implementation of International Health Regulations 2005, WHO will support the establishment of an EPR unit and the strengthening of the national capacity for early warning and rapid response to disease outbreaks. WHO will also continue to build capacity and provide logistics support for adequate response during emergencies. A broad coordinated intersectoral approach towards emergency and humanitarian action will be promoted. In addition, support will be provided for health risk assessment and building of core capacity of the government for implementing International Health Regulations (IHR) 2005, with multisectoral involvement to address regional and global disease threats.

WHO will support the national authorities and other partners, finalize and implement the National Contingency Plan on Health, that addresses natural and man-made disasters and disease outbreaks. The analyzed humanitarian context will lead to the development of projects on emergencies as part of the contingency plan and strengthening the capacity of the disease prevention and control division for rapid response to emergencies. WHO will continue to support national authorities in health coordination; rapid health assessment; provision of essential drugs and supplies; training and supervision of health personnel; and development and review of contingency plans with changing situations; and strengthen the capacity of Disaster Management Department of the Office of the National Security for coordination of emergency preparedness and response.

Neglected tropical diseases are re-emerging in Sierra Leone. In response, WHO will support the development of tools to sensitize communities to identify and report NTDs and the scaling up of community-based surveillance of interventions. In addition, support will be strengthened for surveys to monitor the trends of NTDs. The documentation and sharing of best practices in the control of NTDs will be also be supported.

1.5: Prevent and reduce diseases, disability and premature deaths from noncommunicable conditions, including injuries, mental disorders, malnutrition, and environmental and occupational health risks

High consumption of tobacco, changes in eating habits, increasing substance abuse, widespread lack of physical activity and an unregulated food and beverage industry are increasingly leading to noncommunicable diseases (NCD). The epidemic of noncommunicable diseases causes adverse effects on both health and wealth. WHO support will focus on the promotion of healthy living, enforcement of relevant laws and generation of evidence for programmes and policies that aim to reduce lifestyle-based risks for the individuals as well as for the community. The development of the Sierra Leone national strategic plan for primary prevention of noncommunicable diseases will be supported.

Special efforts will be made for the collection of data that will be necessary for NCD prevention. WHO's step-wise surveillance approach will be followed to generate data on risk factors for major NCDs and their disease burden and consequent deaths. Priority NCDs to be addressed include diabetes mellitus, hypertension, ischaemic heart disease, stroke, and cancers of the lungs, breast and cervix.

Toward the reduction of risks associated with the use of tobacco, WHO will support the accession of the government of Sierra Leone to the Framework on Tobacco Control and the creation of smoke-free environment. WHO will also strengthen the evidence-base for decision making, including the setting up of baseline, through youth tobacco and school personnel surveys and the monitoring of risk factors for tobacco, as well as other NCDs.

In order to accelerate the implementation of the Sierra Leone mental health policy, WHO will support the development of a strategic plan for its implementation. The integration of mental health into the PHC and anti-stigma programme for communities will also be supported, in addition to the training of peripheral health staff on mental health. To strengthen the monitoring of trends of mental health diseases, WHO will focus on prompt reporting of cases and setting up of databases and feedback systems.

Violence, injury prevention and disability remain an important public health intervention. Even though there is no official data on the number of disabled persons in the country, there is a high number of people with disabilities especially in the rural areas. This is on account of the civil war which increased the number of amputees. WHO will support the finalization of the national policy and act on disability and advocate for ratification of the UN Convention on the rights of persons with disabilities; support the review of the strategy on prosthetics and orthotics which was developed with support from WHO and capacity building of the Ministry of Health and Sanitation in taking the lead in coordination of community-based rehabilitation services.

1.6: Promote health and development and prevent risk factors associated with access to safe water and sanitation, the use of tobacco, alcohol, drugs and other psychoactive substances, food safety, unhealthy diets and lifestyles

Increasingly, adverse impacts of environmental determinants of health threaten the achievement of sustainable development in Sierra Leone. WHO's response to this challenge is to continue its multisectoral policy and programmatic advisory service to address priority environmental health issues including pollution of drinking water, inadequate sanitation, indoor air pollution and food safety. More emphasis will be put on the facilitation of evidence–based strategies for the primary prevention of pollution, and identifying and promoting sustainable technologies and approaches to prevent environmental health risks for both urban and rural communities.

WHO will promote preventive approaches to water management using the concept of Water Safety Plans to enable utilities, communities and households to maintain supplies of safe drinking water. Support will be provided to identify approaches and technologies that ensure access to safe water for vulnerable communities. WHO's support for sanitation will also focus on helping the government to achieve the goal of "Total Sanitation by 2015" and ensure that this achievement is sustainable in the long term.

WHO will emphasize capacity building of government institutions to develop effective management frameworks that will ensure the safety of food from the production stage to consumption. Support will be provided to strengthen government capacity to monitor food safety with modern approaches and techniques.

Strategic Priority 2: Reduce infant, child and maternal morbidity and mortality, and promote responsible and healthy sexual and reproductive health behaviour

Sierra Leone has one of the highest child and maternal mortality rates in the world. Efforts to stem this tide of illnesses and deaths and the consequent economic burden will remain top priority for WHO. Increased support will be provided to the MOHS and the newly established RCH department. WHO will continue to support capacity building that aims to improve the health of mothers, children, adults and the ageing population through a

life-cycle development approach but with special attention to universal access to quality sexual and reproductive health, family planning and adolescent health. In line with the rights-based approach to sexual health, the reproductive health needs of both genders will be addressed. A community focus and adherence to the principles of PHC remain central to WHO support. The capacity for operational research and utilization of evidence-based information on reproductive and sexual health will also be enhanced.

Main Focus:

2.1: Reduce infant and child morbidity and mortality, and improve adolescent health

WHO will support the review of the RCH policies and strategic plan and the adaptation and use of guidelines, standards and tools for improving neonatal survival and enhancing health services for mothers, newborns, infants, children and adolescents. Support will be provided to the MOHS and partners to ensure that comprehensive packages utilizing rights-based approach to interventions for integrated management of both childhood illness and pregnancy and childbirth (which include those for the full newborn period) will be scaled up nationwide and progress monitored. This will require a continuum of care between maternal, newborn and child health services and strengthened links between these and other programmes, such as immunization, family planning, nutrition, HIV/AIDS and malaria control.

In the area of child and adolescent health, WHO will support the development of adolescent health strategy and guidelines and monitor their implementation. Adolescent-friendly health services will be integrated into routine service delivery, which will promote a comprehensive package that addresses tobacco, alcohol and substance abuse, risky sexual behaviour, injury prevention and safety; and strengthen systems for systematic monitoring and improvement of the quality of care for child and adolescent health services at all levels.

Research will be conducted to formulate evidence-based policies and strategies to mobilize the participation of individuals, families and communities, and to improve access to quality services with the aim of ensuring continuum of care for safe motherhood and newborn health, including the provision of maternal and newborn care at community and primary care levels, especially for low birth-weight infants. WHO will continue to support integrated monitoring and review of child and adolescent programme interventions as well as their impact, including systems for monitoring trends in neonatal survival, disaggregated by sex, that allow the detection of subgroups at high risk.

2.2: Reduce maternal morbidity and mortality and enhance access to high quality sexual and reproductive health services, ensuring continuum of care throughout the lifecycle

Support will be provided for innovative approaches for equitable access to gender-sensitive health services, including reproductive health services for both women and men, that will also include operationalization and scaling up of adolescent-friendly health services and strengthening of community-based care for healthy and active ageing. Attention will be paid to strengthening human resources capacity, providing supportive environment to ensure skilled care for every birth, and ensuring a continuum of care between communities and facilities, with referral care at all times, in particular for marginalized populations and communities. Support will also be provided to strengthen monitoring and auditing systems that identify maternal deaths and detect failures of the health system to meet needs, especially those of marginalized and underserved groups in Sierra Leone. WHO will support research to address maternal health and gender issues, empowerment of women and domestic violence, sexual and reproductive health care and interventions, especially at health facility and community

levels.

To support the comprehensive integration of nutrition throughout the lifecycle into the health sector framework, WHO will support effective and efficient institutionalization of nutrition programmes for enhancing synergies in service delivery as well as programme monitoring and evaluation. Research and development of technologies and interventions for micronutrient supplementation throughout the lifecycle will be strengthened. Support will also be continued for operationalization of the strategic plan for infant and young child feeding and management of severe malnutrition in healthcare facilities.

Domain 2: Health System Capacities and Performance

Strategic priority 3: Strengthen health policies and systems to improve access and quality of services

WHO support will focus on enhanced functionality of the district health system, strengthening of the capabilities of MOHS in collecting and analyzing financial information for decision making, and strengthening human resource capacities at all levels. Traditional healing system as well as operational research strengthening at national and district levels will be supported. WHO will also support improved capacity of MoHS to increase access for quality medicines.

WHO's aim is to support comprehensive health systems development at national, district and sub-district levels. WHO will continue to strengthen the evidence-base for policy and planning, regulatory and organizational development through research into demand and supply-side factors, workforce skill-mix, biomedical technology, pharmaceuticals, and patient safety issues including clinical waste management. WHO will, together with partners, support the Government of Sierra Leone in the implementation of the Sierra Leone Vision 2025 health agenda and the MOHS Rolling Plan (2008-2010) to ensure increased utilization levels and enhance the impact of health services.

Main Focus:

3.1: Strengthen the organizational, human resource and managerial capacity of the national and district health systems for delivering high quality and safe care, with special focus on vulnerable groups

WHO will support the formulation of policies and plans for scaling up the training of nurses, midwives, health technologists and community health workers. It will develop tools for the proper utilization of the workforce, including the use of task shifting and the collection and analysis of information on human resources for health through HRH observatories. Enhancing the capacity of professional regulatory bodies and associations involved in improving the quality of education and practice, in partnership with the national network of public health training institutions for both pre-service and in-service education, strengthening policy and advocacy on HRH employment and deployment that favour retention of health personnel will remain a main focus of WHO during the period 2008-2013. WHO will continue to support the revision of health training institutions as need arises. WHO will strengthen operational research for evidence-based information and decision making.

In support of alternative healthcare financing for equitable access to health care, WHO will provide technical expertise for the development of alternative healthcare financing schemes, including social health insurance, and demand-side financing mechanisms. Support will also be provided for the generation of evidence for improvement in allocative efficiency

and equity while also assisting the MoHS in its efforts to introduce and sustain health components in social safety net schemes.

To strengthen the organizational and managerial capacity of the national and local health systems for delivering accessible, quality and safe care to the communities, with special focus on vulnerable groups, WHO will provide support to enhance the service mix, service quality and service responsiveness of health service delivery institutions, particularly at the district level. Special attention will be given to interventions that focus on eliminating demand-side barriers. Support will also be provided to address healthcare associated risks through patient safety measures such as blood safety, hand hygiene, safe injection practices, hospital waste management and other areas of facility-based quality assurance.

3.2: Enhance national capacity to ensure access to quality essential medicines, vaccines and medical technologies, including safe blood transfusion, medicines and medical supplies and laboratory services

Support will be directed towards developing the capacity of the National Regulatory Authority in ensuring quality medicines and vaccines, monitoring the impact of the current drug policies on access to essential medicines, and promoting the rational use of drugs. WHO will support regular updates of national medicines policy, essential medicines lists and clinical guidelines to respond to changing environment, promote transparent medicines pricing through provision of information, and strengthen procurement and supply chain management of medicines and other health supplies. Harmonization, coordination and information management of procurement, stocking and distribution of medicines and supplies for specific health programmes will be enhanced. WHO will also support the Ministry of Health and Sanitation in the evaluation of the medicines policy and strategies implementation; strengthen stakeholders in the pharmaceutical sector implement and monitor national drug policies and improve access to essential drugs for priority diseases such as HIV/AIDS, TB and malaria. Further support will be provided for effective implementation of the policy on blood transfusions and enhancing access to quality public health laboratory services. WHO will support the development of the national laboratory policy and strategic plan which will guide the performance of diagnostics in the country as well as strengthen the Central Reference Laboratory to provide oversight to the district and tertiary laboratories.

3.3: Strengthen evidence-based health information for decision making, including health systems and operations research

As Sierra Leone rebuilds its information infrastructure and systems, WHO will increase its support to strengthen the national health information system, in data collection, reporting, analysis and dissemination. Collaboration will be strengthened with partner agencies and networks, including the Health Metrics Network. Support will also be provided for capacity building for knowledge management and modernization of health libraries in the country. Focus will be placed on conducting needs-based quality health research, developing and managing effective health research information systems, and generating and disseminating evidence for informed decision making. WHO will support MoHS develop national policy on health management information systems.

Domain 3: PARTNERSHIPS, ADVOCACY, GENDER AND EQUITY

Strategic priority 4: Foster partnerships and coordination for national health development

WHO will provide, within the scope of this strategic agenda, technical assistance to the MOHS and development partners in support of the implementation of health sector programmes. In addition, WHO will continue its liaison function with respect to global alliances / funds, foundations and nongovernmental organizations. Technical assistance in support of primary health care will be strengthened.

WHO will work with UN Gender Theme Group to support the implementation of the National Gender Strategic Plan on areas related to gender and health.

Main Focus:

4.1: Promote collaboration and alignment to strengthen health development partnerships

WHO will support the MOHS to work effectively with donor partners to ensure that national health development goals and strategies are achieved through alignment of donor support with government priorities, in line with the Paris Declaration. Special attention will be given to supporting the leadership role of the MOHS in health sector programmes, including the national health system reforms, medicines and health technologies as well as human resource development in Sierra Leone.

WHO will facilitate positive dialogues among health development partners to identify key implementation and policy issues, promoting the result of the dialogue with the MOHS and other related ministries. To enhance resource mobilization, WHO will provide the MoHS and NGOs with required technical assistance to develop project proposals to access global funds and global partnerships. Such activities will be supported through resources from WHO HQ, Regional Office and the country office.

4.2: Strengthen WHO Country Presence in Sierra Leone – physical presence and technical backstopping from the WHO Regional Office for Africa and Headquarters

WHO country presence, which includes its physical presence as well as its integrated technical backstopping from Regional Office and Headquarters, will be strengthened to ensure effective capacity to meet the need of the new strategic agenda contained in this CCS. The WHO country office will ensure human resource policies and practices that attract and retain top talent, promote learning and professional development, manage performance, and foster ethical behaviour.

The work of the country office will be guided by strategic and operational plans that build on lessons learnt, reflect country needs, and that can be used to monitor performance and evaluate results. Management strategies, policies and practices will be put in place for the Global Management System (GSM) and other information systems, which will ensure reliable, secure and cost-effective solutions, while meeting the changing needs of the country office. This will enable the country office to work as a flexible, learning team, enabling it to carry out its mandate more efficiently and effectively.

In cognizance of the increasing tempo of programmatic and financial operations envisaged during the period of this CCS, and in order to improve the quality and responsiveness of

outputs, key managerial and administrative support services necessary for the efficient functioning of the WHO country office need to be strengthened. Sound financial practices and efficient management of financial resources will also be pursued through continuous monitoring and mobilization of resources to ensure the alignment of resources with the programme budgets.

The physical working environment will be improved and maintained to ensure offices that are conducive to the well-being and safety of staff, as well as inter-agency collaboration.

Box 6: WHO/Sierra Leone Strategic Priorities and Approaches, 2008-2013

Strategic Domains	Strategic Priorities	Main Focus
A: Health Security	**1: Reduce the health, social and economic burden of communicable and noncommunicable diseases**	1.1: Strengthen prevention and control of malaria
		1.2: Combat HIV/AIDS and tuberculosis.
		1.3: Enhance capacity of the national immunization programme for effective prevention and control of vaccine-preventable diseases.
		1.4: Support for effective integrated disease surveillance, preparedness, response and control of communicable diseases, including the implementation of International Health Regulations.
		1.5: Prevent and reduce diseases, disability and pre-mature deaths from noncommunicable conditions, including injuries, mental disorders, malnutrition, and environmental and occupational health risks.
		1.6: Promote health and development and prevent risk factors associated with access to safe water and sanitation, the use of tobacco, alcohol, drugs and other psychoactive substances, food safety, unhealthy diets and lifestyles.
	2: Reduce infant, child and maternal morbidity and mortality, and promote responsible and healthy sexual and reproductive health behaviour	2.1: Reduce infant and child morbidity and mortality, and improve adolescent health.
		2.2: Reduce maternal morbidity and mortality and enhance access to high quality sexual and reproductive health services, ensuring continuum of care throughout the lifecycle.
B: Health System Capacities and Performance	**3: Strengthen policies and systems to improve access and quality of services**	3.1: Strengthen the organizational, human resource, healthcare financing, health and environment and managerial capacity of the national and district health systems for delivering high quality and safe care, with special focus on vulnerable groups.
		3.2: Enhance national capacity to ensure access to quality essential medicines, vaccines and medical technologies, including safe blood transfusion, medicines and medical supplies and laboratory services.
		3.3: Strengthen health information and evidence-base for decision-making, including health systems and operations research.
C: Partnerships, Gender and Equity	**4: Foster partnerships and coordination for gender responsive national health development**	4.1: Promote collaboration and alignment to strengthen health development partnerships.
		4.2: Strengthen WHO country presence in Sierra Leone – physical presence and technical backstopping from Regional Office and Headquarters.

Within the UNDAF framework and orientations on the need for one-UN compound, the physical re-location of the WHO country office may be needed. Adequate budgetary provisions need to be made for this strategic event.

5.2 LINKAGES OF THE STRATEGIC AGENDA WITH SIERRA LEONE GOVERNMENT, WHO AND UNDAF PRIORITIES

This Country Cooperation Strategy is rooted in WHO policies and strategies, aligned with national priorities, and harmonized with the work of United Nations and other partners in Sierra Leone. The strategic agenda of this CCS – comprising of the strategic priorities and main focus – have strong linkages with the national health priorities of the government of Sierra Leone. It also has strong linkages with the six core functions of WHO and the WHO strategic objectives of the Medium-Term Strategic Plan 2008-2013 (MTSP) which form the current policy, planning and implementation framework for WHO's work at the country level. Tables 6 and 7 illustrate how and where the CCS country-specific strategic priorities are linked with the Sierra Leone MoHS and WHO MSTP priorities. The strategic agenda also has strong linkages with the current WHO African regional orientations and UNDAF/Sierra Leone priorities (see Annex IV and V).

Table 6: WHO-Sierra Leone CCS Strategic Priorities

S/N	MoHS/Sierra Leone Priorities	1: Reduce the health, social and economic burden of communicable and non communicable diseases	2: Reduce infant, child and maternal morbidity and mortality, and promote gender responsive and healthy sexual and reproductive health behaviour	3: Strengthen policies and systems to improve access and quality of services	4: Foster partnerships and coordination for national health development
1	To improve the delivery and quality of health care.	++	+++	++	+++
2	To reduce maternal, infant and under-five morbidity and mortality.	++	+++	++	+
3	To increase accessibility and affordability of health services to a greater percentage of the population.	+	+	+++	++
4	To reduce morbidity and mortality due to malaria and other communicable diseases.	+++	++	+	++
5	To reduce the incidence of HIV/AIDS and other sexually transmitted diseases.	+++	++	++	++
6	To reduce malnutrition, especially among women and children.	++	++	+	+

+ + +: Very strong linkage; + +: Strong linkage; +: Some linkage

Table 7: Linkages between WHO Medium Term Strategic Plan and Sierra Leone CCS 2008-2013 Strategic Priorities

S/N	MoHS/Sierra Leone Priorities	1: Reduce the health, social and economic burden of communicable and non-communicable diseases	2: Reduce infant, child and maternal morbidity and mortality, and promote gender responsive and healthy sexual and reproductive health behaviour	3: Strengthen policies and systems to improve access and quality of services	4: Foster partnerships and coordination for national health development
1	To reduce the health, social and economic burden of communicable diseases.	+++			++
2	To combat HIV/AIDS, tuberculosis and malaria.	+++	+	+	++
3	To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.	+++		+	++
4	To reduce morbidity and mortality and improve health during key stages of life.	++	+++		++
5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.	+++	+		++
6	To promote gender sensitive health and development, and prevent or reduce risk factors for health conditions.	+++			++
7	To address the underlying social and economic determinants of health.	++			++
8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors.	++			++
9	To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development.	++			++
10	To improve the organization, management and delivery of health services.			+++	++
11	To strengthen leadership, governance and the evidence base of health systems.			+++	+++
12	To ensure improved access, quality and use of medical products and technologies.			+++	++

S/N	MoHS/Sierra Leone Priorities	1: Reduce the health, social and economic burden of communicable and non communicable diseases	2: Reduce infant, child and maternal morbidity and mortality, and promote gender responsive and healthy sexual and reproductive health behaviour	3: Strengthen policies and systems to improve access and quality of services	4: Foster partnerships and coordination for national health development
13	To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes.	+	+	+++	++
14	To extend social protection through fair, adequate and sustainable financing.			+++	++
15	To provide leadership, strengthen governance and foster partnership and collaboration with countries.	+	+	++	+++
16	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.	+	+	+	+++

SECTION 6

IMPLEMENTING THE STRATEGIC AGENDA

In order to ensure effective implementation of the Sierra Leone CCS 2008-13, it is essential to outline the implications for the WHO country office in Sierra Leone, the WHO Regional Office for Africa (AFRO) based in Brazzaville, as well as the WHO Headquarters (HQ) in Geneva.

6.1 IMPLICATIONS FOR WHO COUNTRY OFFICE

The implications of the CCS 2008-13 for the WHO country office (WCO) in Sierra Leone will be outlined in terms of the following:

(a) Expanding the use of the Country Cooperation Strategy;

(b) Core competencies and capacities of WCO/Sierra Leone team;

(c) Integrated programmatic and technical support from regional offices and headquarters;

(d) Effective functioning of the country office;

(e) Knowledge management and information; and

(f) Working with organizations of the United Nations system and development partners.

6.1.1 Effective Implementation of the Country Cooperation Strategy

As the basis for developing a "one WHO country strategy, plan and budget", the WHO country office in Sierra Leone will ensure that the CCS will remain central to all planning and budgeting processes. The CCS shall be the basis for the WCO biennial and annual workplans and for dialogue with the stakeholders in Sierra Leone. The CCS shall be revised as required, based on appropriate consultations with all stakeholders, especially the Government of Sierra Leone.

6.1.2 Integrated Programmatic and Technical Support from Regional Offices and Headquarters

In order to implement the "one WHO country plan and budget", based on the CCS, and to respond swiftly to epidemics and other emergencies, an integrated programmatic and technical support will be required from AFRO and the WHO Intercountry Support Team for Eastern and Southern Africa (IST). The soon-to-be-operational WHO Global Management System (GSM) will support this process.

6.1.3 Better Knowledge Management

WCO/Sierra Leone, as a knowledge-based office, will strive to make better use of its aggregate knowledge to promote better health in Sierra Leone. The WCO will also strive to become better at learning and knowledge sharing, and will ensure that up-to-date information

on countries and WHO country offices is available and easily accessible to stakeholders. The WCO/Sierra Leone website will be operational and the required ICT manager will support this process.

6.1.4 Effective Functioning of the Country Office

An enabling work environment, with increased administrative and managerial efficiency as well as adequate logistics and field security, will allow the Sierra Leone WHO Country Team to carry out WHO core functions in line with the CCS. All staff will be provided the training needed to effectively utilize the GSM and the related information systems and to improve their management and leadership competencies, as required. A learning committee has been established to coordinate this process. Investments are required in strengthening the ICT infrastructure needed to support the increasing ICT needs. The common UN compound in Freetown was vandalized during the war in the 1990s. The UNCT is currently re-establishing common UN Services. It is envisaged that some UN agencies, including WHO, may move into a new UN compound during the period covered by this CCS. Adequate budgetary allocation should be made for this important issue.

6.1.5 Core Competencies and Capacities of WHO Country Office

It is essential that the country office in Sierra Leone possesses the required set of competencies to effectively execute this Country Cooperation Strategy. The WHO country office in Sierra Leone currently has 13 technical officers on its staff, consisting of three international and 10 national officers. The shift in approaches and emphasis, as articulated in the strategic agenda, would mean some shift in resource allocation, in the staff profile and the development of new capacities within the country office.

The estimated composition of staff at the country office required for successful implementation of WHO collaborative programmes under each strategic priority is provided in Table 8. The changes in post requirements are shown in Table 9.

Table 8: Estimated changes in the country office staff to fully implement the CCS 2008-2013

Strategic Priorities	International Professionals		National Professionals	
	Current	Required	Current	Required
1. Reduce the health, social and economic burden of communicable and noncommunicable diseases.	2	2	6	8
2. Reduce infant, child and maternal morbidity and mortality, and promote responsible and healthy sexual and reproductive health behaviour.	0	1	1	1
3. Strengthen policies and systems to improve access and quality of services.	0	1	2	4
4. Foster partnerships and coordination for national health development.	1	2	1	1
Total	**3**	**6**	**10**	**14**

Table 9: Changes in Post Requirements

Post Type	Name of Posts
1. New International Posts to be created.	1.1 Child and Adolescent Health (CAH) 1.2 Health Systems Strengthening (HSS) 1.3 Administrative Officer (AO)
2. New National Professional Officer posts to be created.	2.1 Information and Evidence for Decision Making (HIE) 2.2 Noncommunicable diseases (NCD)/Mental Health 2.3 Essential Drugs and Medicines (EDM) 2.4 Information and Communications Technology (ICT)
3. Posts to be Re-profiles / Abolished.	3.1 Human Resources for Health (HRH)

It is recommended that the following three new international posts be created: Child and Adolescent Health (CAH), Health Systems and Administrative Officer (AO) posts. The CAH post will strengthen WHO's strategic leadership and contributions toward addressing the urgent need to reduce the very high childhood as well as the maternal mortality rates in Sierra Leone. To enhance support for the holistic approach of the MOHS and partners toward health system strengthening, the proposed Health Systems Officer position is essential, particularly as this post-conflict country consolidates its peace and development phase. The post of an international Administrative Officer needs to be created in order to ensure adequate management and accountability for the increasing resources that the WCO now has to manage. Besides the low adult literacy rate (25% in 2002-203), many qualified people that were displaced during the war are yet to return to the country. The dearth of highly qualified persons makes it essential to recruit international staff members to these important posts.

The Human Resources for Health (HRH) post needs to be abolished, as the Health System post holder will also support human resource strengthening issues. However, an Information and Evidence for Decision Making (HIE) national professional officer post is recommended, to strengthen the WCO's capacity to work with the MoHS and partners to rebuild the post-war information system in the country. A noncommunicable diseases (NCD), including mental health national officer, post is also recommended to strengthen the WCO's capacity to support the MOHS in addressing the increasing burden of noncommunicable diseases and post-war drugs and mental health issues.

Additionally, a national programme officer for Essential Drugs and Medicines (EDM) would be required to strengthen WHO's leadership role in ensuring the availability of safe essential drugs, medicines and medical technologies and in strengthening the capacity of the national regulatory authority to ensure effective monitoring of clinical trials of drugs and vaccines. In view of the huge resources available to the country from global funds and other donors, this remains a strategic opportunity for WHO.

Effective use of modern information and communication technology is essential for WHO's support to all programmes in Sierra Leone. An information and communications technology (ICT) national officer post is required in order to provide the needed ICT competencies to the country office. The post holder will also support the WCO's broader knowledge management needs and the rollout and maintenance of the WHO Global Management System (GSM).

6.1.6 Working with Organizations of the United Nations System and Development Partners

Partnerships have become a key feature of WHO's work in Sierra Leone. The WCO will ensure that the CCS will remain the basis for all WHO input into the UNDAF, the SWAp, PRS and other health and development processes in Sierra Leone. The WCO will be proactive in identifying new opportunities for synergy and harmonization of its work with that of other UN agencies and development partners. Above all, WHO Sierra Leone commits to providing high-quality technical support to all stakeholders toward the attainment of "Health-for-All" in Sierra Leone.

6.2 IMPLICATIONS FOR WHO REGIONAL OFFICE

The Regional Office will continue providing technical support to the country office for implementing the strategic agenda in the areas where expertise is not available in the country. With the establishments of the Intercountry Support Teams (IST), it is expected that the IST/ Western Africa, based in Ouagadougou, Burkina Faso, will provide more of the needed technical support, as may be necessary. Moreover, regional and IST assistance will usually be required to address emergency and humanitarian situations in order to provide timely support in emergency situations. The upcoming rollout of the WHO Global Management System (GSM) in 2008/9 will facilitate the integration of programmatic and technical support from AFRO and the Intercountry Support Team.

6.3 IMPLICATIONS FOR WHO HEADQUARTERS

In keeping with its mandate, WHO Headquarters will continue to provide the regional and country offices with global policy advice, directives on health development, and guidance on global norms and standards. In addition, it will advocate the cause of the country and take action for resource mobilization for the country at the global level.

With their broad-based networks, the Regional Office and HQ are also required to facilitate inter-country collaboration and multi-country activities for transfer of technology, sharing of experience, expertise and resources between countries within and outside the Region. This will enable WHO Sierra Leone to address common issues of interest as well as learn of best practices, effective strategies and approaches for health development in other countries.

While the country office has to be proactive in mobilizing resources to secure the funds required for effective implementation of the strategic agenda, support will also be needed from AFRO and HQ in mobilizing additional resources, especially for emergencies and epidemic response. It is essential to ensure the adequate funding of the management and administration requirements of the WHO country office in Sierra Leone. As much as possible, these should be included in donor-supported projects with WHO.

6.4 RESULTS-BASED MANAGEMENT: MONITORING AND EVALUATING THE COUNTRY COOPERATION STRATEGY

This Country Cooperation Strategy will be executed through three consecutive biannual programme budgets and workplans. Within the framework of the WHO results-based management system, these workplans include a robust monitoring framework of intervention-specific indicators – which include Office-Specific Expected Results and key Products and Activities. WHO's regular six-monthly monitoring of workplan implementation progress will be complemented by periodic in-depth evaluations of select programmes to determine their impact on national health development. When necessary, thematic evaluation of some key areas / issues will also be undertaken.

ANNEX I

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ANNEX II

SIERRA LEONE COUNTRY COOPERATION STRATEGY (2008–2013) DEVELOPMENT PROCESS

The second generation of the Sierra Leone CCS (2008-2013) started with the constitution of a CCS Formulation Team, headed by the WR/Sierra Leone and co-chaired by the Deputy Chief Medical Officer who is also Director of Primary Health Care of the Ministry of Health and Sanitation (MOHS). The CCS Formulation Team was charged to review the first Country Cooperation Strategy (CCS 2004-2007) and identify the gaps that need to be addressed in the second generation Country Cooperation Strategy (CCS 2008-2013).

In order to improve the awareness and the use of the CCS 2008-2013, the development process emphasized three key issues:

(a) In-depth review and analysis of the key health sector issues, including the factors that influence the health status of Sierra Leoneans.

(b) Broad consultations and advocacy for the CCS (2008-2013) preparation process, to ensure that the process was inclusive and participatory.

(c) Active involvement of key stakeholders, especially the MoHS, health development partners and WCO staff.

Members of the Formulation Team reviewed all relevant documents, including the Budget Framework of Sierra Leone Health Sector for the years 2007-2008 to 2009-2010, Sierra Leone National Health Priorities and Strategic Plan for 2004-2005 and 2010-2011, and the Vision 2025. Others were the Sierra Leone Poverty Reduction Strategy, Health–related Millennium Development Goals, WHO Global and Regional Strategic Plans/Directions, The Medium Term Strategic Plan 2008-2013 of WHO and the United Nations Development Assistance Framework 2008-2012 of Sierra Leone. The priorities gathered from these, together with the gaps and recommendations from the review of CCS 2004-2007, defined the priority areas of CCS 2008-2013.

The CCS 2008-2013 development process involved extensive discussions with the Ministry of Health and Sanitation, UN agencies and development partners in both public and private sectors in Sierra Leone. The WR met with the UN Country Team to inform and acquaint them with the process for the CCS 2008-2013 development.

There were broad consultations and advocacy for the preparation for the CCS 2008-2013, taking into consideration the global health challenges and targets, the WHO HQ and regional strategic plans and national health priorities. The opportunity was also taken to inform and acquaint the monthly health task force review meetings where the MoHS, multilateral organizations, bilateral organizations, the NGOs, private sector and civil society are represented to present the CCS 2008-2013 process and priorities.

During the WHO staff retreat at the end of 2007, the top senior staff in the MoHS including the Minister of Health and Sanitation and Deputy, directors and programme managers were again consulted and the draft CCS 2008-2013 document was given to them for comments and inputs.

The comments from the MoHS and other partners were incorporated into the draft document. This was followed by several discussions and consultations internally within the WCO/Sierra Leone to fine-tune and strengthen the document. The draft CCS 2008-2013 document was also shared with the UN heads of agencies for comments. All these consultations provided the foundation needed for alignment with the national priorities.

We would like to acknowledge with gratitude the immense invaluable contributions of the consultant, Dr A. Onyeze, from the AFRO/ICST/ESA and Dr P. A. T. Roberts of the MoHS. We express our gratitude to the Regional Office and Headquarters for their orientation in the finalization of the document.

CCS Formulation TeamCCS FORMULATION TEAM

WHO Country Team

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Dr Felicitas Zawaira	Representative (2006-2007)
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Ministry of Health and Sanitation

Dr Arthur Williams	Chief Medical Officer
Dr P.A.T. Roberts	Deputy Chief Medical Officer, Dir. Primary Health Care
Dr Clifford Kamara	Director, Planning and Information and Management

ANNEX III

SWOT ANALYSIS FOR IMPLEMENTING THE CCS

The possible strengths, weaknesses, opportunities and threats have been identified for implementation of the CCS as reflected in the table below.

Strengths	Weaknesses
• Capacity for quick response to outbreaks and epidemics. • Accessibility and availability of WHO technical guidelines. • Availability of full complement of staff with diverse skills. • Focus at strategic engagement v Space and location of the country office. • Telephone and other means of communication and connectivity capacity. • Availability of transport for project activities. • Team spirit within WHO country office.	• Weak documentation practices. • Inadequacy of funds. • CCS not sufficiently being used as a planning tool. • Weak monitoring within the country. • Overloaded staff members due to thin staffing of the office. • Lack of coordination and follow-up on implementation of the plans by different role players. • Inadequate funding and technical resource to support implementation of the plans. • Regular reviews/monitoring of CCS implementation by all partners have not been formalized. • Non-availability of key WHO technical staff at the country level.
Opportunities	**Threats**
• Good relations and collaboration between WHO and MoHS. • Good collaboration and cooperation with other UN agencies, ADB, EU, DFID, Irish Aid and NGOs. • Prompt technical back-up from AFRO, IST and WHO/HQ. • Greater authority and empowerment of WRs for decision-making. • Clear monitoring mechanisms from AFRO, IST and HQ.	• Uncertainty of extra-budgetary funding. • High turn-over of counterparts at MoHS. • Perceptions that WHO is a funding institution. • Human resource situation in the health sector.

ANNEX IV

LINKAGES BETWEEN AFRO PRIORITIES AND STRATEGIC OBJECTIVES AND CCS STRATEGIC PRIORITIES

S/N	AFRO Regional Priorities and Strategic Objectives	WHO-Sierra Leone CCS Strategic Priorities			
		1: Reduce the health, social and economic burden of communicable and non-communicable diseases	2: Reduce infant, child and maternal morbidity and mortality, and promote gender responsive and healthy sexual and reproductive health behaviour	3: Strengthen policies and systems to improve access and quality of services	4: Foster partnerships and coordination for national health development
1	A more structured engagement by WHO at the national health policy level.	+	+	+	+++
2	Strengthening WHO's role in supporting the development of national health systems.	+	+	+	++
3	Working with Member States and partners to support the scaling up of public health programmes.	+++	++	++	++
4	Ensuring that in times of crisis all affected populations, including displaced people, have access to essential health care.			+++	+
5	Harmonizing WHO efforts with those of the United Nations and, where appropriate, with other development partners in line with the priorities of the Member States.	++	++	++	+++

+ + +: Very strong linkage; + +: Strong linkage; +: Some linkage

ANNEX V

LINKAGES BETWEEN SIERRA LEONE UNDAF AND CCS STRATEGIC PRIORITIES

S/N	Sierra Leone UNDAF Priorities	WHO-Sierra Leone CCS Strategic Priorities			
		1: Reduce the health, social and economic burden of communicable and non-communicable diseases	2: Reduce infant, child and maternal morbidity and mortality, and promote gender responsive and healthy sexual and reproductive health behaviour	3: Strengthen policies and systems to improve access and quality of services	4: Foster partnerships and coordination for national health development
1	UNDAF Outcome 3: Improved health for children under five and women of child-bearing age with emphasis on reduction in child and maternal mortality rates.	+++	++	++	++
2	UNDAF Outcome 5: By 2010, the national response to HIV/ AIDS is strengthened through increased access to prevention, treatment, care and support services and reduction of stigma and discrimination.	+++	++	++	++

+ + +: Very strong linkage; + +: Strong linkage; +: Some linkage