SIERRA LEONE CHILD SURVIVAL ACTION PLAN

2023-2025

TABLE OF CONTENTS

LIST OF ABBREVIATIONS FOR THE CSAP

AIDS	Acquired Immunodeficiency Syndrome
AfDB	African Development Bank
CHC	Community Health Centre
CHW	Community Health Worker
CMAM	Community Management of Acute Malnutrition
CMO	Chief Medical Officer
CS	Child Survival
CSA	Child Survival Action
CSAP	Child Survival Action Plan
CDs	Communicable Diseases
DHIS-2	District Health Information System-2
DHMTs	District Health Management Teams
DHS	Demographic Health Survey
DMOs	District Medical Officers
DPPI	Directorate of Policy Planning and Information
ENAP	Every Newborn Action Plan
CH	Child Health
EPI	Expanded Programme on Immunization
EPMM	Ending Preventable Maternal Deaths
ETAT	Emergency Triage Assessment and Treatment
FCDO	Foreign, Commonwealth & Development Office
FMCs	Facility Management Committees
Gavi	Global Alliance for Vaccines and Immunization
GC7	Grant Cycle 7 of The Global Fund to Fight AIDS, Tuberculosis and Malaria
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GFF	Global Financing Facility
GIZ	German Agency for International Cooperation
HCW	Health Care Worker
HWs	Health Workers
HMIS	Health Management Information System
iCCM	Integrated Community Case Management

IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illnesses
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IsDB	Islamic Development Bank
JDs	Job Descriptions
JAICA	Japan International Cooperation Agency
LRTIs	Lower Respiratory Tract Infections
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
MNCH	Maternal Newborn and Child Health
MoHS	Ministry of Health and Sanitation
MoU	Memorandum of Understanding
NCDs	Non-Communicable Diseases
NMCP	National Malaria Control Programme
NMSA	National Medical Supplies Agency
PHC	Primary Health Care
PHUs	Peripheral Health Units
PMNCH	Partnership for Maternal, Newborn and Child Health
QMP	Quality Management Programme
QoC	Quality of Care
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health
RMNCAH & N	Reproductive Maternal Newborn Child and Adolescent Health and Nutrition
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goal
SLeSHI	Sierra Leone Social Health Insurance
SOPs	Standard Operating Procedures
ToR	Terms of Reference
TWG	Technical Working Group
U5MR	Under-Five Mortality Rate
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDCs	Village Development Councils
WASH	Water, Sanitation and Hygiene
WHA	World Health Assembly
WHO	World Health Organization

FOREWORD

On 23 May 2022, on the margins of the 75th World Health Assembly (WHA), Sierra Leone, along with Tanzania, cohosted a roundtable discussion in collaboration with the Child Health Task Force, the Global Financing Facility (GFF), Partnership for Maternal, Newborn and Child Health (PMNCH), Save the Children, United Nations Childre's Fund (UNICEF), United States Agency for International Development (USAID) and World Health Organisation (WHO). Participants of the discussion included the Ministers of Health (or their senior representatives) from several African countries and global health and development leaders. The aim was to reflect on the current state of progress and discuss how to secure renewed commitment and drive equity-enhancing actions to achieve the Sustainable Development Goal (SDG) targets for child survival.

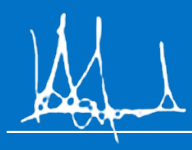
Sierra Leone was selected as a Pathfinder country for Child Survival Action (CSA) due to the commitment made at the highest level to accelerate progress towards achieving the SDG for child survival by 2030. In addition, Sierra Leone is currently among the few countries with unacceptably high under-five mortality rates. Following our commitment during the WHA Side meeting, we have collaborated with the Global Child Task Force and in-country partners and stakeholders to develop Sierra Leon's CSAP, which is the first of its kind. The Action Plan was launched at the second Global Pneumonia Forum in Madrid, Spain, in April this year. This is a milestone achieved by Sierra Leone in delivering its promises for our children and to the rest of the countries and our partners.

The Ministry of Health and Sanitation has declared maternal and child survival an emergency and requested commitment and action similar to the Ebola and COVID-19 pandemics, taking accountability at the highest level with a strong data system to track progress towards achieving our goals.

This CSAP is Part of the overarching national Reproductive, Maternal, Newborn, Child, Adolescent, Health and Nutrition (RMNCAH & N) strategy. It fits very well with the Ministry's Person-Centered and Life Course approach to service delivery for achieving Universal Health Coverage and Health SDGs in Sierra Leone.

The efforts contributed by all levels of leaders and experts from the Ministry of Health and Sanitation and our global and country partners have created considerable momentum and the development and launching of the Sierra Leone CSAP. However, you will agree; operationalizing the Action Plan and achieving the targets within the given time is more challenging. I am confident and believe that if we keep the momentum created and continue our excellent collaborative efforts, we can deliver results together.

Therefore, I would like to call all Development Partners, both donor and technical, to continue their support for implementing the CSAP as a key component of the RMNCAH+N strategy. Finally, I reiterate the Ministry of Health and Sanitation's commitment to elevating and supporting the Child Survival Agenda in Sierra Leone.



Dr Sartie Kenneh

Chief Medical Officer
Ministry of Health and Sanitation

REMARK

Despite the impressive progress in reducing maternal and child mortality in Sierra Leone, we are still among the few countries with the highest under-five mortality at 104.7 per 1000 live births, with 2,700 children under-five dying. Even though the deaths occur in excess in both the neonatal and post-neonatal period, 70 per cent of the mortality occurs in the age group 1-59 months due to preventable or treatable causes such as malaria, pneumonia, diarrhoea in the background of multiple risk factors such as malnutrition, lack of access to quality services including immunization, safe water, hygiene and sanitation, among others. If the current trend continues, Sierra Leone will miss attaining the SDG target of 25 per 1000 live births.

The Ministry of Health and Sanitation has taken a bold step to change the situation; the Honorable Minister of Health and Sanitation (MoHS), Dr Austin Demby, has declared maternal and child survival an emergency and requested all commitment and action similar to that of Ebola and COVID-19 pandemics, taking accountability at the highest level. This has been followed by developing the CSAP for Sierra Leone as an urgent concrete step to accelerate progress towards achieving the Sustainable Development Goal target of 25 or fewer child deaths per 1000 live births by 2030.

The CSAP is one of the three Action Plans Sierra Leone has developed, including the Ending Preventable Maternal Mortality and Every Newborn Action Plan (EPMM/ENAP). The EPMM/ ENAP focuses on pregnancy through newborn (28 days) and aims to cut neonatal mortality level to 23 per 1000 live births by 2025. The CSAP focuses on infancy through early childhood (1-59 months), aiming to reduce the under-five mortality rate to 71 per 1,000 live births by 2025.

We plan to achieve the ambitious targets of the CSAP through strong leadership and accountability at the highest level, improved governance and coordination within the Ministry of Health and Sanitation, including district level, and with donor and implementing partners. We need to align planning, implementation, and monitoring of all programs and projects to optimize investments from different sources and with special focus on districts where the burden is greatest.

The CSAP is embedded in the 2023 revised RMNCAH & N strategy (2017-2025), which outlines strategic priorities for each life stage and underlying systems issues that need strengthening and forms our investment case for the GFF Health Sector Support. It is also an annex to the Reproductive Maternal Newborn Child and Adolescent Health (RMNCHN).

This Action Plan has been developed through a series of consultative engagements of different Directorates and Programs of the MoHS, child survival partners within Sierra Leone and members of the global Child Health Taskforce. I am confident the partnership and commitments demonstrated during the development of the CSAP will continue during its operationalization, and through the Ministry's commitment and efforts combined with the support of our partners and stakeholders, we will achieve the objectives and targets laid in the CSAP by 2025 which will be a milestone to the journey of achieving the SDG target of 25 or fewer child deaths per 1000 live births.

Dr Tom Sesay

Director – Reproductive and Child Health
Ministry of Health and Sanitation

ACKNOWLEDGEMENTS

This CSA was developed through a highly consultative process involving various organizations between November 2022 and April 2023. However, the MoHS wishes to express our profound gratitude to Dr Anne Detjen, Suzanne Fuhrman, Dr Mariama Mustapha, Dr Edwin Lutomia Mangala, Dr Hailemariam Legesse and Yuki Suehiro from UNICEF, and Dr Borrazzo John from MOMENTUM Country and Global Leadership, Dr Binyam Hailu from WHO and Members of the Global Child Health Task Force who worked continuously to support in the development of this document.

We also extend our gratitude to Dr Nellie Bell from Ola During Children's Hospital (ODCH), the Child Health/ Expanded Programme on Immunisation (CH/EPI), RMNCAH and the Directorate of Policy Planning and Information (DPPI) team for their contribution during the development of the Action Plan,

Dr Tom Sesay, the RMNCAH Director, with Dr Lynda Grant, the Deputy Child Health and EPI Program Manger, led and coordinated the whole process, respectively.

The leadership and guidance from Dr Sartie Kenneh, the Chief Medical Officer, was also pivotal in the process.

The MoHS is grateful for the financial and logistic support by UNICEF and USAID for developing and printing the CSAP.

Finally, the MoHS extends its appreciation to all participants from MoHS, Districts and Partners who have made valuable contributions during the consultative and validation meetings of the CSAP as their inputs helped to refine the document.

LMFarma

Dr Lynda Farma - Grant

Deputy Child Health and EPI Program Manger
Ministry of Health and Sanitation

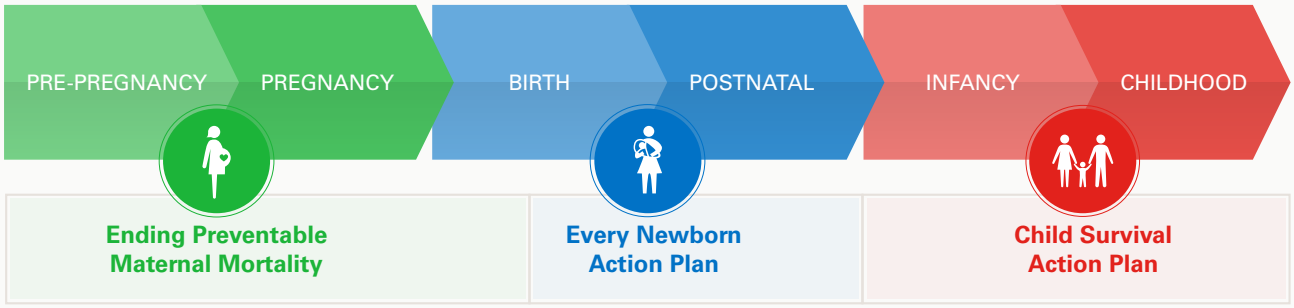
Background

In 2021, over 27,000 children under-five died in Sierra Leone. With an under-five mortality rate estimated at 104.7 deaths per 1000 live births in 2021, Sierra Leone is off track to achieve the 2030 Sustainable Development Target of 25 or fewer deaths per 1000 live births and will only achieve the target after 2050 . The rapid acceleration of progress is therefore needed.

The CSAP is an annex to the revised 2017-2025 RMNCAH & N strategy, which takes a life-stage vision of Health and well-being for women, newborns, children, and adolescents, and recognizes the importance of nutrition to good Health, and outlines priority intervention areas for each life stage. The RMNCAH & N strategy defines prioritized intervention areas for each life stage.

Goal: Refocus efforts, with a holistic approach, to end preventable child deaths in Sierra Leone.
Target: By 2025, reduce the under-five mortality rate to less than 71 per 1000 live births.

The CSAP is one of three action plans that reinforce and further detail, for each life stage, priority actions, milestones, and targets to rapidly accelerate mortality reduction by addressing the specific causes of illness and death.



- The ENAP/EPMM focuses on pregnancy through newborns (28 days). Deaths within the first 28 days of life account for 30% of under-five deaths in Sierra Leone. The country aims to reduce neonatal mortality to less than 23 per 1,000 live births by 2025.
- The **CSAP** focuses on infancy through early childhood (1-59 months), which accounts for **70% of under-five deaths** in Sierra Leone. The country aims to reduce the under-five mortality rate to 71 per 1000 live births by 2025.

The CSAP elevates the child survival agenda to the highest level for visibility and accountability. It calls for expanding strategic investments in Primary Health Care (PHC), with Integrated Management of Newborn and Childhood Illnesses (IMNCI) in facilities and Integrated Community Case Management (iCCM) at the community level defined as key priority strategies among others in the RMNCAH & N strategy.

The CSAP mainly focuses on preventing deaths in the post-neonatal period, among children being left behind and at risk of dying from leading killers—pneumonia, diarrhoea, and malaria—due to multiple risks such as malnutrition, lack of access to quality health services, including immunization, unsafe water and sanitation, air pollution, conflict and humanitarian disasters, and other risks to children's Health and survival. The actions focus on strengthening primary health care services (PHUs and CHWs) with a strong referral system and referral-level care at hospitals. The CSAP outlines the most urgent priorities to focus on to reduce child mortality rapidly.

1 WHO Maternal and Child Epidemiology Estimates Group (MCEE) 2019.

Strategic approaches:

- Tackle issues to improve child health and increase child survival in Sierra Leone by bringing together stakeholders from across the Directorates and Programmes of the MoHS to collaborate for action.
- Joint action of government and partners to end preventable child deaths through addressing programmatic and health system challenges that hamper progress in child survival.
- Leadership, accountability, and action at national, district, health facility and community levels for child survival.
- Expanded strategic investments in PHC, with IMNCI-iCCM among the key priority strategies.

Enablers of Child Survival Action:

- Strong leadership at the political level in the MoHS and RMNCAH Directorate to strengthen the child survival agenda in revising the RMNCAH & N strategy.
- Relevant policies and guidelines are in place, with a vision articulated in the RMNCAH & N Strategy for synergistically supporting child survival.
- Key promotive, preventive, and curative interventions for child survival from community to referral levels are well-defined.
- Systematic efforts to strengthen HMIS, and while there are persistent gaps, the platform is well-established, with a strong desire at all levels to use data for decision-making effectively.
- National RMNCAH & N strategy revision where IMNCI, iCCM, and ETAT are defined as key priority strategies.
- Essential Package of Health Services is under development and will be centred around community-based prevention and care (iCCM, IMNCI, ETAT and hospital care).
- Planning for the Sierra Leone Social Health Insurance (SLeSHI) scheme.
- Shifting strategies, such as the Global Fund, moving away from vertical disease funding.

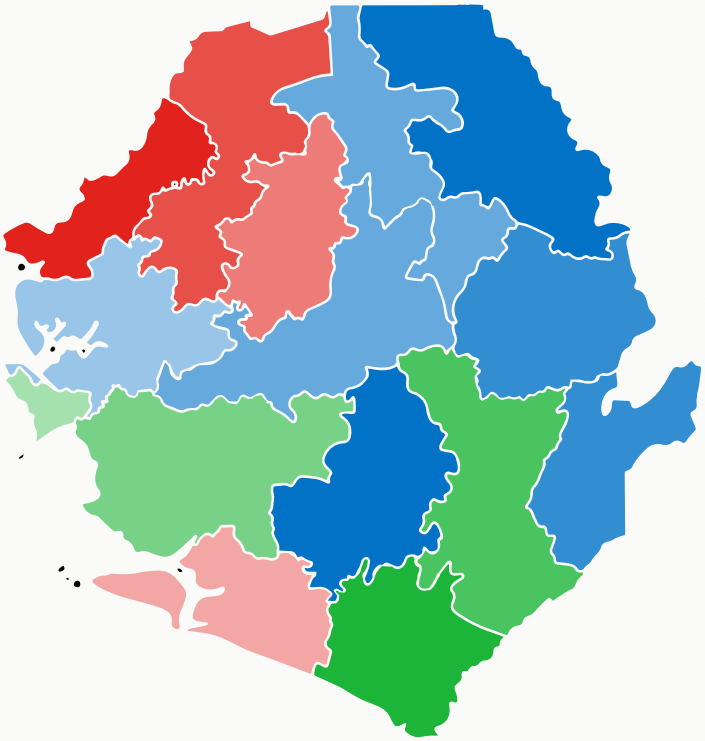
Situational analysis

Sierra Leone has the fifth highest under-five mortality rate among off-track countries at 104.7 per 1,000 live births. Among the per cent of under-five deaths by age group, a substantial proportion of under-five deaths are in the 1–59-month period. Sierra Leone has the highest proportion of under-five deaths in the 1–59-month period (70 per cent).

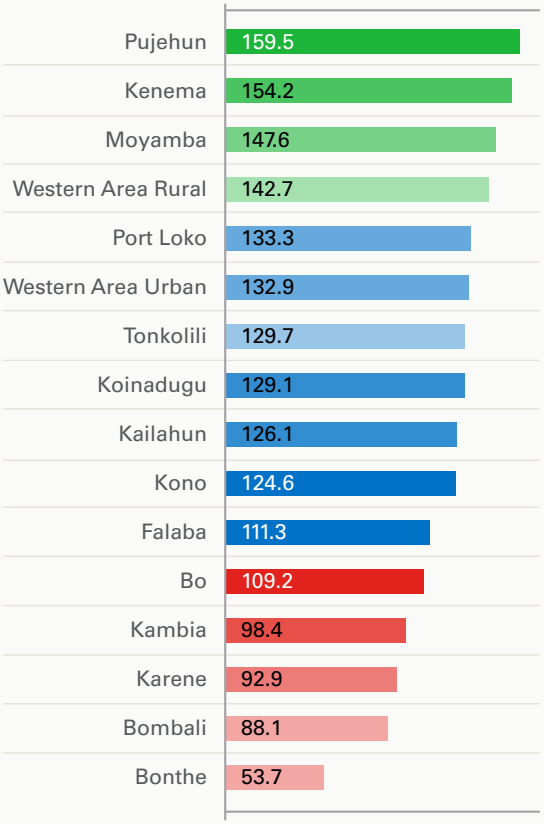
Inequities exist among districts, with higher mortality rates in some areas, with the highest rates in the Pujehun district and the lowest in the Bonthe district. There is an almost three-fold difference between districts with the lowest and highest mortality rates (see Figure 1).

Figure 1. Under-five mortality rate per district, UN IGME for 2021.

Admin 2: UN IGME for 2021 - Sierra Leone

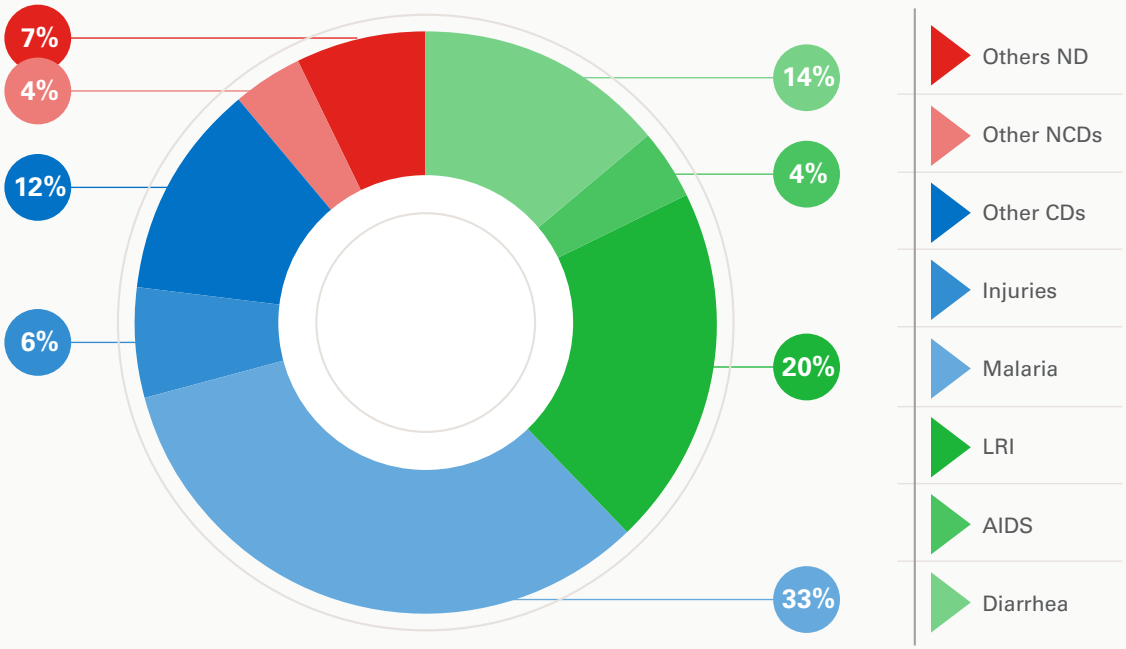


Admin 2: UN IGME for 2021 (Bar) - Sierra Leone



The leading causes of death in children 1-59 months in Sierra Leone are malaria (33 per cent), pneumonia (20 per cent), and diarrhoea (14 per cent). Malnutrition remains an important underlying cause of under-five mortality. These diseases are preventable and commonly treatable at the primary healthcare level (see Figure 2).

Figure 2. Causes of under-five mortality beyond the neonatal period in Sierra Leone.



Among all-cause mortality, over half of under-five deaths occur in rural areas and at home[2]. Considering underlying, intermediate, and immediate causes of death among infants and children (rather than underlying condition alone), the evidence shows that malnutrition, malaria, and sepsis are the most common underlying causes and that pneumonia, sepsis, malaria, and anaemia are the most common immediate causes of death[3].

Objectives of the Child Survival Action Plan

- Elevate Child Survival Action to the highest level for visibility and accountability.
- Improve Child Health data collection, management, and use at all levels.
- Improve the quality-of-service delivery, primarily through building healthcare worker skills/competencies and quality improvement.
- Improve visibility and ownership of quantification and stock monitoring of Child Health commodities, advocate with partners to support, and engage in distribution and consumption monitoring.
- Ensure all children in hard-to-reach areas can access iCCM and that CHWs implement preventive/promotive health and nutrition interventions.
- Understand the role and ways to engage the private sector better to deliver essential Child Health services.

2 Carshon-Marsh R, Aimone A, Ansumana R et al. 2022, 'Child, maternal, and adult mortality in Sierra Leone: nationally representative mortality survey 2018-20,' The Lancet Global health, (2022), e114-3123, 10(1)

3 CHAMPS Annual Advisory Forum meeting presentation, preliminary findings, Sierra Leone, April 2021.

Leadership and accountability

The CSAP is developed as a Ministry-wide plan under the overall leadership of the Minister of Health and Sanitation. Regular progress for child survival will be reported to the Minister of Health and Sanitation by the Chief Medical Officer and the Director of RMNCAH.

The Director of RMNCAH is responsible for coordinating with other Directorates and Programmes within the Ministry and with partners. The Child Health Programme will be established under the RMNCAH Directorate, with the Program Manager responsible for leading the Child Health Programme and coordinating the implementation of the CSAP.

At the district level, the Child Health Focal Points will oversee implementation, monitoring and reporting, and coordination within the District Health Management Team and with the Medical Superintendents of the hospitals. Districts will regularly report progress to the Director of RMNCAH.

Sierra Leone Child Survival Action Plan 2023-2025: Bottlenecks, Objectives and Actions

National Target (2025)	By 2025, reduce the under-five mortality rate (U5MR) to less than 71 per 1000 live births.

Actions	**Tasks**	**Milestones**		**2025 Target**
		2023	**2024**	
Bottleneck 1: Leadership and governance in Child Health at national and subnational levels, especially engagement and alignment of multiple stakeholders in child health inside and outside the government.				
Objective 1: Elevate Child Survival Action to the highest level for visibility and accountability.				
1. Create a Child Health Programme under RMNCAH Directorate	Review Child Health governance and accountabilities within RMNCAH Directorate and across directorates/ programmes and MoHS leadership.	Child Health Programme established by June 2023, and accountabilities clearly defined among all Directorates.	First annual performance review was conducted based on JDs and TORs, and feedback used to inform improvements.	By 2025, a Child Health Programme at national level is functional with regular progress monitoring for Child Survival.
	Recruit Child Health Programme Manager and technical staff with clear Terms Of References and Job Descriptions, including collaboration across Directorates and Programmes.			
	Develop a costed annual work plan at the national level across the MoHS departments.	2023 Annual work plan for Child Health finalized and communicated to all districts.	2024 Annual work plan for Child Health finalized and communicated to all districts.	
	Establish regular reporting mechanism on progress for Child Survival to the Minister of Health and Sanitation.	Monthly progress update on Child Survival to Senior Management (CMO/ Executive Management Committee, UHC Core Team).	Monthly progress update on Child Survival to Senior Management (CMO/ Executive Management Committee, UHC Core Team).	

	Develop a Child Health programme Monitoring and Evaluation Tool for mid-year and annual performance tracking.			
2. Establish functional Child Survival coordination within the MoHS and with partners	Reconstitute Child Survival Technical Working Group with lead, secretariat, clear TORs with partners/ MDAs.	Child Survival coordination platform established.		By 2025, a Child Survival coordination platform within MoHS, partners and MDAs will be functional and effective.
	Within MoHS: nominate Child Health Focal Points in key directorates/ programmes with refined working relationships/areas of collaboration and joint work plan.	Child Health Focal Points at national and sub-national levels nominated with clear TORs		
	Increase efficiencies across all relevant directorates/ programmes in MoHS: Child Health Programme, Quality Management Programme (QMP), Directorates of Nutrition, PHC and NMCP to jointly plan implementation activities (e.g., training, supervision, mentoring/ coaching, stock monitoring etc.).	2023/2024 annual work plan for Child Health Programme developed jointly with other directorates/ programmes within and outside MoHS	Child Survival activities are reflected in the annual work plans of all directorates/programs in MoHS.	
	Leverage Child Survival TWG to strengthen coordination, collaboration, and accountability around priorities for Child Survival: ensure donor and implementing partners/MDAs' activities are based on national priorities and plans.	a) Monthly CS TWG meetings b) Partner plans on Child Survival aligned with MoHS plans at the national level.	a) Quarterly CS TWG b) Partner plans on Child Survival aligned with MoHS plans at the national level.	

3. Empower Child Health leadership at the district level	Ensure districts know national plans and priorities, optimize/ align resources across programmes, and increase effective/ integrated implementation.	CSA disseminated and popularized to all districts by Dec 2023.		By 2025, DHMTs will prioritize Child Survival activities in district work plans and budgets.
	Capacitate Child Health Focal Point (e.g., District Health Sister) at the district level with a clear job description/ TOR to oversee implementation, monitoring, and reporting; and to coordinate within DHMTs and with medical superintendents.	Child Health Focal Points nominated and capacitated in each district by Dec 2023.		
	Strengthen Child Survival governance and coordination at the district level (e.g., TWG or other).	50% of districts with a functional MNCH TWG by Dec 2023.	100% of districts with a functional MNCH TWG by Dec 2024.	
	Strengthen national-district coordination for Child Health: DMO to report progress for CSA at the national level, covering the entire district.	50% of districts provide monthly progress reports and recommendations on CSA through DMO / CS focal person.	100% of districts provide monthly progress reports and recommendations on CSA through DMO / CS focal person.	
	Costed annual work plan for Child Survival implementation activities at the district level.	2023 Annual work plans at districts capture Child Health activities per the CSA.	2024 Annual work plans at districts capture Child Health activities per the CSA.	
	Ensure partners implement the government priorities; service level agreements are properly implemented.	Partner plans on Child Survival aligned with 70% of MoHS plans at the district level.	Partner plans on Child Survival aligned with 100% of MoHS at the district level.	

4. Optimize resource allocation and utilization for Child Survival	Regularly map key actors, resources, and gaps; identify opportunities for optimized resource allocation; and track expenditures.	Specific financing opportunities (Global Fund, Gavi FPP, World Bank, GFF, COVID-19, FCDO, USAID, UKAID, Irish AID, China AID, JICA, IsDB, AfDB, Foundations, Gates, Warren Buffet, others) to address joint priorities are targeted.	65% of the CSA budget is funded.	By 2025, at least 80% of budgeted activities supporting Child Survival funded, with funding fully utilized.
	Designated directorate to define and cost the PHC minimum package for integrated Child Health services delivery.	Essential health service package for UHC finalized and launched by Dec 2023.	Essential health service package for UHC implemented by Dec 2024.	
	Advocacy by the Child Health Programme to Ministry of Health and Sanitation leadership for the inclusion of Child Survival actors in complete proposal development processes for major funding opportunities.	GF funding mechanisms (GC7, BIRCH, CR19), Gavi, USAID, FCDO, World Bank, GFF, Irish Aid, JICA, GIZ, China AID, Islamic Development Bank, African development Banak, Foundations, LAD portfolio plan contributes to key CSA priorities and support integrated delivery platforms.		
	Advocate for and allocate adequate resources to address Child Health priority activities at the district level.	50% of Child Health priorities at the district level are adequately funded as reflected in district budgets by Dec 2023.	100% of Child Health priorities at the district level adequately funded as reflected in district budgets by Dec 2024.	
5. Advocacy for Child Survival Action	Develop and implement a national CSA advocacy plan/action.	Partners are aware and supportive of the CSAP.	Partners are aware and supportive of the CSAP.	By 2025, champions and stakeholders will support the implementation of the CSAP through advocacy.
	Identify and empower high-level/prominent champions (beyond the Minister of Health and Sanitation).	A champion is supporting advocacy for the CSAP by June 2023.	At least 2 champions are supporting advocacy for the CSA Plan by June 2024.	
	Identify and empower district and chiefdom-level champions.		District and chiefdom-level champions are advocating for the CSA Plan by June 2024.	
	Advocate for resource allocation for child survival.		Champions and stakeholders advocate for domestic financing and development funding for Child Survival.	

Actions	Tasks	Milestones		2025 Target
		2023	2024	
Bottleneck 2: Lack of quality data for child health, including accountability and oversight for reporting and use across all levels				
Objective 2: Improve the collection, management, and use of Child Health data at all levels.				
6. Strengthen the data management system to generate evidence for Child Health	Strengthen Health Management Information System by selecting and integrating indicators related to Child Health (process/ outcome/ scorecard, etc.); consider incorporating qualitative data for the care experience.	Critical Child Health/ paediatric indicators are included in the DHIS-2.	Critical Child Health/ paediatric indicators are reported.	By 2025, the DHIS-2 is strengthened for Child Health and generates quality data which is analyzed and used to improve the programme.
7. Ensure the quality of Child Health data	At the national level, appoint M&E personnel in the Child Health Programme to oversee data quality and identify and act on bottlenecks while working with DPPI and other Directorates, as appropriate.	M&E personnel are appointed, trained, supported, and deployed in the Child Health Programme.	Focal Points are identified and trained at the facility level to support quality Child Health data collection, analysis and use.	
	Districts to oversee the process of Child Health data collection in facilities including PHUs and community level, analysis and use of the data towards strengthening Child Health service delivery.			
	Identify and train facility focal points, including PHUs, for RMNCAH data.			

8. Analyse and report/ feedback on data analysis to relevant stakeholders	Take action through monthly data review meetings by the Child Health Programme Manager for key Child Health indicators, led by the RMNCAH Directorate to oversee the Quality of Care and RMNCAH scorecard.	Review, analysis and feedback mechanisms for data are strengthened.	Review, analysis and feedback mechanisms for data are functional and regularly used.	
	Quarterly Child Health Bulletin created by the Child Health Programme.			
	Regular (monthly) review of district Child Health data in CHC, Hospitals and by DHMT (Revise the job description of DMO/ DHMT to include data analysis related to Child Health)			
	Quarterly joint review and feedback meetings at the DHMT level (can be virtual) led by Child Health Focal Point.			

Actions	Tasks	Milestones		2025 Target
		2023	2024	
Bottleneck 3: Poor adherence to norms, standards, and guidelines for care at community, PHU, and referral levels.				
Objective 3: Improve the quality of service delivery, especially HCW skills/competencies and quality improvement.				
9. Scale up and institutionalize quality improvement for integrated Child Health services across hospitals and to the PHC level	National and district levels jointly review key bottlenecks in delivering quality Child Health intervention packages (e.g., prevention, iCCM/ IMNCI, CMAM etc.) for each level of care, including community, PHU, hospital, and referral and back-referral.	Review meetings for bottlenecks in the delivery of Child intervention packages held, and recommendations followed up.	Review meetings for bottlenecks in the delivery of Child intervention packages held, and recommendations followed up.	By 2025, the Quality of Care for Child Health intervention packages improves as measured by paediatric quality of care indicators.
	Identify tracer indicators to measure progress in quality improvement of integrated Child Health and nutrition intervention packages (IMNCI/iCCM, preventive package, ETAT, IMAM etc.)	Tracer indicators selected.	Tracer indicators are reported on.	

	Revitalize and strengthen the already established child death audit dashboard for improved decision-making by the Child Health Programme.	Child health death audits are used in all hospitals.	Child health death audits are used in all hospitals, PHUs and community level.	
10. Scale up/ intensify mentoring and coaching for integrated Child Health and nutrition interventions	Apply a common approach for standardized mentoring/coaching for Child Health interventions (based on national mentorship framework and best practices developed by in-country partners), including tools and scorecards to assess HCW competency against established paediatric QoC standards.	Mentorship approach and framework defined.	Mentorship of HCWs undertaken.	By 2025, mentoring and coaching is regularly undertaken, and issues addressed to support quality Child Health interventions.
	Provide quarterly supportive supervision for integrated Child Health interventions.	Quarterly supportive supervision for Child Health interventions is undertaken.	Quarterly supportive supervision for Child Health interventions is undertaken.	
11. Revise comprehensive pre-service training curriculum for Child Health	Engage with training institutions (Doctors, Nursing, CHWs, etc.) to review and revise pre-service training curriculums to be adequate for the delivery of Child Health and nutrition intervention packages (IMNCI/iCCM, ETAT, IMAM, etc.) led by the Directorate of Training and supported by the Child Health Programme in collaboration with other relevant programmes/ directorates and Child Survival TWG.	Training institutions identified and engaged in revising pre-service training curriculums for Child Health intervention packages.	Pre-service training curriculums were revised to include components of Child Health interventions.	By 2025, revised pre-service training curriculums, which include components of Child Health interventions, are rolled out.
12. Scale up integrated in-service training for key Child Health and nutrition interventions	Standardize training packages for Child Health priority interventions, and develop a comprehensive training plan.	Training packages for Child Health intervention packages are mapped out and standardized.	Comprehensive plan for training for integrated delivery platforms is finalized and costed.	By 2025, the in-service training database is in use, and in-service training rolled out.

	Establish a database of HCWs trained in Child Health and nutrition interventions, map training needs and plan comprehensively for integrated delivery platforms (e.g., iCCM/ IMNCI: Child Health, nutrition, NMCP and PHC) and ensure the capacitated pool of trainers is available.	Database established of trained HCWs.	Pool of trainers for Child Health interventions is available.	

Actions	Tasks	Milestones		2025 Target
		2023	2024	
Bottleneck 4: Stockouts or unavailability of essential child health commodities at community, PHU, and referral levels.				
Objective 4: Improve visibility and ownership of quantification and stock monitoring of Child Health commodities, advocate with partners to support and engage in distribution and monitoring of consumption.				
13. Ensure accountability for quantification, distribution, and monitoring of use of essential Child Health commodities	Ensure regular monitoring of stocks of essential Child Health commodities at the district level and report up to inform distribution, including: 1. Multistakeholder (programmes & partners) quantification is done at every facility. 2. Introduce a facility electronic monitoring system to capture data; and 3. Onsite storage, monitoring, and verification of reporting for quality assurance and accountability.	Complete quantification data for Child Health commodities is available from 50% of districts.	Complete quantification data for Child Health commodities is available from all districts.	By 2025, facilities are transitioning to more of a pull system relying on effective quantification, distribution, and monitoring of essential Child Health commodities.
	Child Health programme through RMNCAH Directorate is engaged in National Supply Chain TWG and the TWG subsets.	Regular engagement with National Supply Chain TWG for Child Health commodities.	Regular engagement with National Supply Chain TWG for Child Health commodities.	
	Designate District Child Health Focal Points as a part of the existing Quantification TWG to oversee these efforts and identify and act on bottlenecks.	All essential Child Health commodities, beyond malaria, are included in Quantification TWG.	All essential Child Health commodities, beyond malaria, are included in the annual quantification process.	

14. Ensure prioritization of Child Health commodities in all relevant procurements, both on-budget and in-kind	Include non-malaria commodities in the GC7 (NFM4) of GF: Quantify the needs for non-malaria commodities in iCCM to be included in the GF proposal (Gap analysis). Ensure a designated focal point in MoHS to lead this effort.	GF proposal developed and submitted by June 2023, including non-malaria commodities.	Non-malaria commodities supported through Global Fund procured and reached CHWs.	By 2025, Child Health commodities are funded at all levels.
	Prioritize Child Health commodities in potential new funding opportunities.	Potential funding opportunities for the inclusion of Child Health commodities are identified.	Proposals are written to include Child Health commodities.	
	Advocate for cost recovery scheme (drug revolving fund)/ SLeSHI in facilities to make Child Health commodities available—including child health commodities in existing cost recovery schemes at tertiary hospitals.	Child Health commodities are included in ongoing procurement, policy, and financial frameworks for cost recovery schemes/ SLeSHI.	Cost recovery schemes/ SLeSHI with the inclusion of Child Health commodities are rolled out.	
	Strengthen visibility (e.g., dashboard) of what is procured and distributed, including quantification at the national and district level for Child Health commodities, based on the data from the DHIS-2 and Event Management tool.	Dashboard is used to alert RMNCAH Directorate of gaps in Child Health commodities.	Dashboard is used to alert RMNCAH Directorate of gaps in Child Health commodities.	
	Leverage recent and ongoing medical oxygen investments to ensure the availability of appropriate equipment and clinical capacity for hypoxemia management in children.		Medical oxygen investments are available at CHCs to support children.	
15. Strengthen distribution by decentralizing the process from district to facilities and CHWs	District to complement the distribution function of NMSA using local government resources/allocated resources for last mile distribution focused on redistribution/resupply (reverse logistics) to facilities between quarterly distributions.	Plans developed for redistribution/ resupply of Child Health commodities to facilities between quarterly distributions.	Redistribution/resupply of Child Health commodities is done for 50% of facilities between quarterly distributions.	By 2025, Child Health commodities are available at the facility and community levels, including the last mile.

	Orient district pharmacists and partners about using data to inform the allocation of drugs and supplies for iCCM, IMNCI and first-level referral care.	Orientation for district pharmacists about the use of data is undertaken.	District pharmacists are using data to inform the allocation and distribution of Child Health commodities.	
	Ensure both PHUs and CHWs are equipped/do not have stockouts of essential Child Health commodities (e.g., pre-pack for CHWs pending completion of the ongoing pilot)	Findings from the pilot of pre-pack for CHWs in hard-to-reach areas are used to ensure CHWs have Child Health commodities.	Ensure 100% of CHWs in hard-to-reach-areas have Child Health commodities available.	

Actions	Tasks	Milestones		2025 Target
		2023	2024	
Bottleneck 5: Inadequate community outreach and services to promote care-seeking, prevent childhood illnesses, and treat children in hard-to-reach areas				
Objective 5: Ensure all children in hard-to-reach areas can access iCCM and preventive/promotive health and nutrition interventions implemented by CHWs.				
16. Intensify health education and advocacy with communities, connected to ongoing and strengthened campaigns, including amplification by CHWs	Support the operationalization of the SBCC strategy for RMNCAH, including a review of Child Health-specific messages.	SBCC strategy is reviewed for inclusion of Child Health specific messages.	Develop Child Health specific messages as necessary.	By 2025, caregivers of children in hard-to-reach areas are reached with Child Health-specific messages.
	Engage at the community level through intensified messages, community engagement meetings, and feedback with stakeholders such as local councils, chiefs, civil society organizations, religious leaders, tribal leads, traditional healers, facility management committees (FMC), village development councils (VDCs), ward committees, town criers, and mother support groups.	Health Education Department is engaged in supporting Child Health interventions.	Intensified messages and engagement with community stakeholders are regularly undertaken.	
	Support and strengthen campaigns (e.g., Immunization Day, Child Health Weeks, etc.)	Child Health specific messages are regularly included in campaigns.	Child Health specific messages are regularly included in campaigns.	

	Ensure promotional and preventive Child Health messages (e.g., sanitation and hygiene promotion, care-seeking, immunization) are part of CHW amplification at community amplification.	Child Health-specific messages are reviewed in the CHW package.	Child Health-specific messages are strengthened in the CHW package.	
17. Improve PHU support for CHWs	Plan, monitor, supply, and support monthly meetings of PHU in-charges with CHWs.	Monthly meetings of the PHU in-charge with CHWs are undertaken.	Number of communities and children reached by CHWs is increased.	By 2025, PHU support for CHWs is strengthened.
	Strengthen supervision, partner audits, work with district leaders, and partnerships in supervision.	Supervision and partner audits are undertaken.	Supervision and partner audits are undertaken.	
18. Strengthen home visits by CHWs and other community-level agents (e.g., WASH, Agriculture), leveraging multi-sector engagement at community level	Improve CHWs' ability to undertake home visits (e.g., procurement of bicycles, motorbikes, transport refund) through community health-focused grants (e.g., Global Fund).	Proposals submitted for potential funding opportunities (e.g., Global Fund) to support CHWs to undertake home visits.	CHWs in hard-to-reach areas are supported to undertake home visits.	By 2025, children in hard-to-reach areas receive quality curative, preventive, promotive and treatment services.
19. Strengthen systems of accountability, especially community feedback	Improve the use of client chatters, radio programs, community radio, and community scorecard.	Pilot Community Scorecard in 2 districts.	Community Scorecard is scaled up among the districts.	By 2025, the Community Scorecard is used in all districts.

Actions	Tasks	Milestones		2025 Target
		2023	2024	
Bottleneck 6: Actual and potential role of private sector providers is not fully exploited.				
Objective 6: Understand the role of and ways to better engage the private sector for the delivery of essential Child Health services.				
20. Build the capacity of private providers in the diagnosis and treatment of childhood illness according to national guidelines	Understand the role of and map private providers in diagnosing and managing childhood illnesses.	Establish MOU between MoHS and the association of private sector providers to ensure accountability, data sharing, knowledge sharing, and use of guidelines and tools.	Mapping of private providers is completed, and guidelines are established.	By 2025, relevant public-private partnership MOUs, SOPs and guidelines are developed.
	Work with private provider associations/ representatives on how to engage private providers in capacity-building efforts.			

	Provide training for selected private providers on diagnosing and managing childhood illnesses.			
21. Use the private sector as a partner in filling child health service delivery gaps	Establish a referral and service provision system from public facilities to private hospitals when care cannot be provided (e.g., stockout of key commodities).	Child Health Programme to work with relevant directorates/ programmes in MoHS to engage in public-private partnership.		
	Strengthen innovations that could support child health, such as telemedicine, through a possible public-private partnership.		Mapping and planning for innovations with the private sector is completed.	

Child Survival Action Plan Development in Sierra Leone

- Sierra Leone is a pathfinder for the CSAP, which started with the leadership and commitment of the Minister of Health, H.E. Dr Austin Demby, at the World Health Assembly (WHA) in May 2022.
- The Minister declared maternal and child survival a national emergency and designated a lead in the MoHS to coordinate the response efforts[4].
- In November 2022, a joint stakeholder mission was undertaken to support the development of the CSAP as part of the RMNCAH & N strategy. Consultative meetings were held with stakeholders, and a debriefing session was held with the Minister, including discussions on the key priorities requiring his leadership.
- The CSAP Validation Workshop, as a part of the first meeting of the Child Survival TWG, was held in March 2023. The meeting was attended by 29 participants representing the MoHS Directorates, Programmes and partners. The participants validated the 21 key actions across the 6 bottlenecks.
- The CSAP will be launched nationally, followed by dissemination to the districts.

History of Child Health Implementation in Sierra Leone

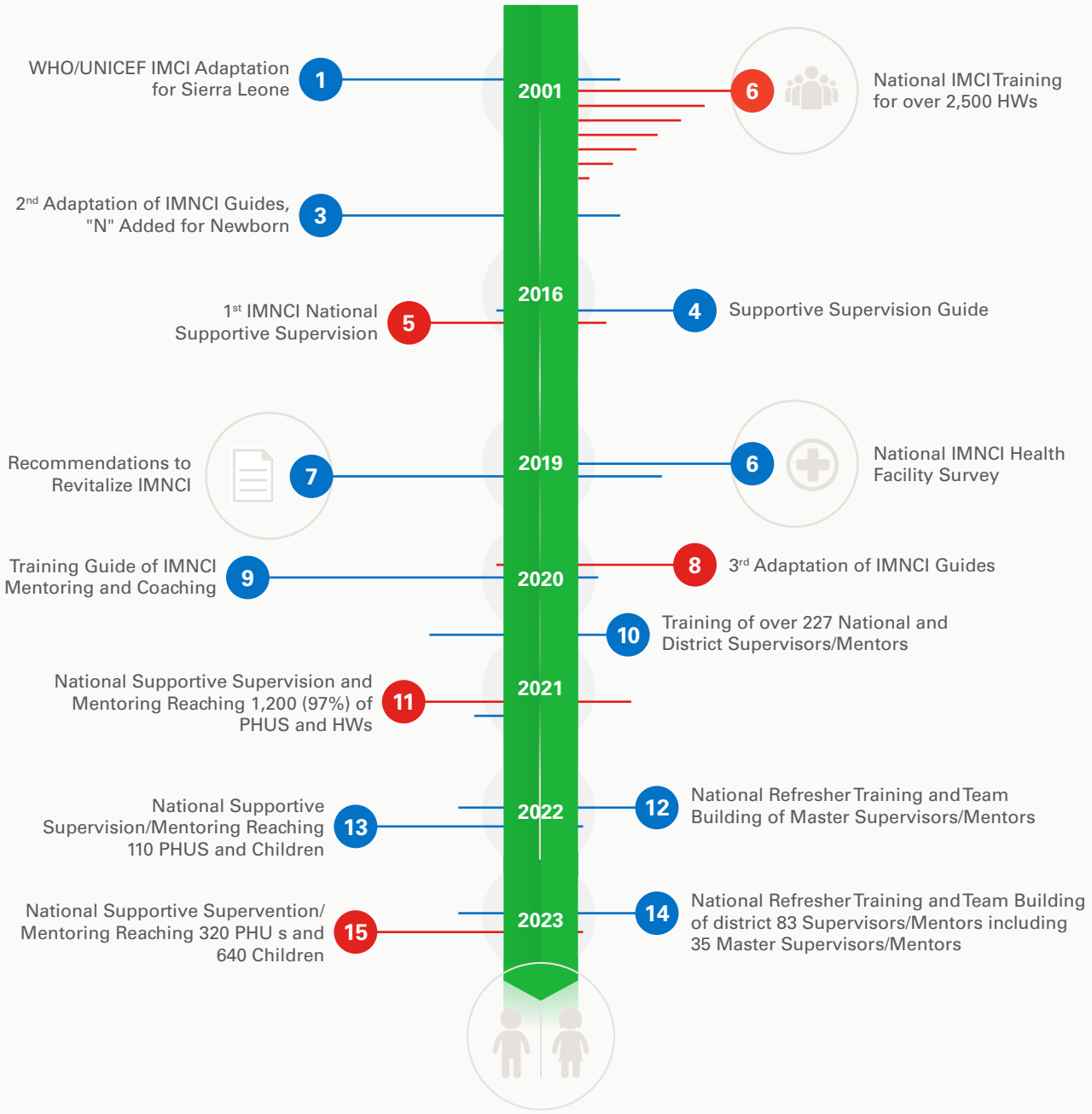
- Immunization first started in Sierra Leone in the 1960s, leading to the initiation of the Expanded Programme on Immunization (EPI). After establishing the EPI programme unit, the programme was expanded to cover Child Health. Child Health is under the EPI programme as a part of the RMNCAH Directorate, and funding is solely focused on EPI activities.
- Sierra Leone adopted IMCI in 2001, followed by national IMCI training for over 2,500 health workers. Guidelines, including a supportive supervision guide, were developed and later adapted to include the newborn, resulting in the IMNCI guidelines in 2016.
- The first national IMNCI supportive supervision took place in 2016, followed by a national IMNCI Health Facility Survey with recommendations to revitalize IMNCI, in 2019. After a 3rd adaptation of the IMNCI guidelines in 2020 and the development of a training guide for IMNCI mentoring and coaching in 2020,

4 https://www.childhealthtaskforce.org/events/2022/05/child-survival-action-roundtable-discussion-accelerated-progress-towards-2030

training was conducted for over 220 national and district supervisors as mentors. By 2021, national supportive supervision and mentoring reached 1,200 (97 per cent) PHUs and health workers. In 2022, national supportive supervision and mentoring reached 110 PHUs and health workers. A national refresher training and team building of master supervisors/mentors was held in 2022 using a digital tool called Kobo Collect (see Figure 3).

- At the community level, Sierra Leone has adopted Integrated Community Case Management (iCCM) nationally through Community Health Workers following the 2012 national CHW policy. Currently, iCCM is implemented in hard-to-reach communities at a national scale. The iCCM implementation by CHWs is synchronized with the IMNCI implementation in Peripheral Health Units (PHUs), as the iCCM is a version of IMNCI accustomed to CHWs.

Figure 3. History of IMNCI in Sierra Leone.



SIERRA LEONE CHILD SURVIVAL ACTION PLAN

2023-2025