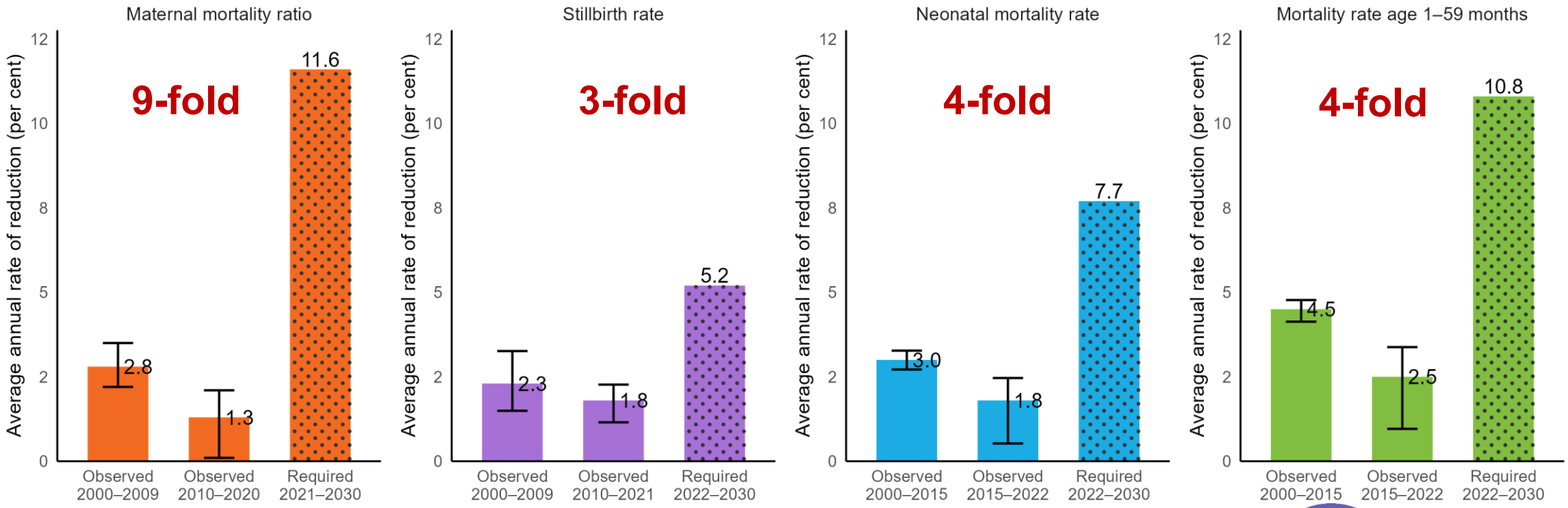
CHILD SURVIVAL ACTION IN SIERRA LEONE

Lessons learned from operationalizing the Sierra Leone Child Survival Action Plan 2023-2025 at national and subnational levels

5 November 2025

Too many countries are off track: Significant acceleration of current annual average rates of reduction (AARR) of mortality is required to achieve the SDG targets.



Two global partnerships in support of achieving SDG 3.1 and 3.2

EWENE Every Woman Every Newborn Everywhere

CHILD HEALTH TASK FORCE

CHILD SURVIVAL ACTION

World Health Organization

unicef for every child

UNFPA

GLOBAL FINANCING FACILITY

Save the Children

World Health Organization

unicef for every child

Source: UNICEF analysis based on estimates from the UN Inter-agency Group for Child Mortality Estimation: Report 2023

Child survival action

Focus on 1-59 month mortality in 60 off-track countries, especially those with high proportion of under-5 child deaths among 1-59 month children

CSA works in support of country led efforts and priorities to

- promote health and reduce risk
- prevent illness
- diagnose and treat key causes of illness and death through integrated PHC with functioning referral systems

….and **leverages the broad network of CHTF (Child health task force)** members for advocacy, learning, country engagement and support

In close coordination with EWENE to ensure alignment

- Catalyze country leadership & accountability
- Strengthen country level technical coordination platforms and inter-departmental coordination in MoH
- Prioritize actions with clear milestones and targets
- Elevate country needs
- Align partners, and resources – Global and at country level
- Track commitments and progress
- Foster cross-country learning

From commitment to action – the example of Sierra Leone

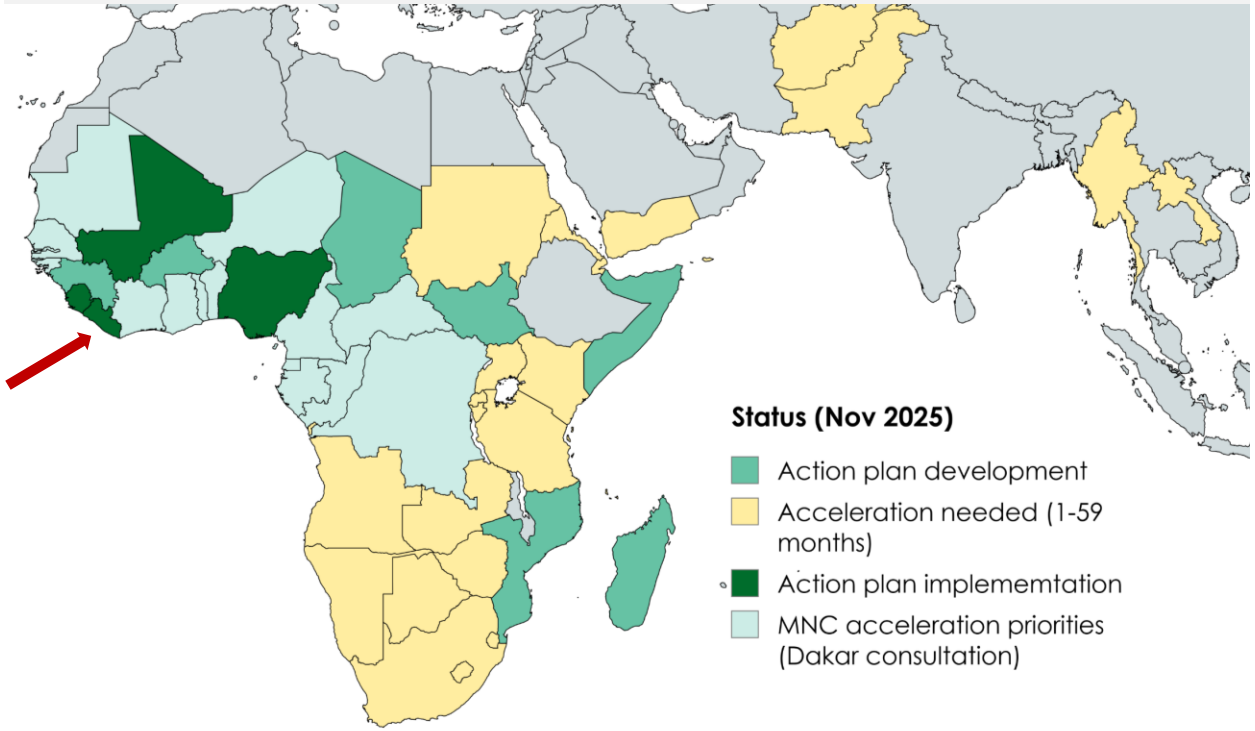
Sierra Leone has been a champion of child survival action from the beginning

- Minister Demby hosted First high-level roundtable at WHA 2022
- Launch of CSA at the 2nd Global Forum on Childhood Pneumonia in Madrid 2023
- Launch of Sierra Leone Child Survival Action Plan 2023-2025 under RMNCAH strategy

Objectives of this webinar

- Share progress and lessons learned operationalizing the Sierra Leone Child Survival Action Plan
- Share experiences from operationalizing the child survival action plan in Kenema District

Prioritized Action in countries off-track to achieve the 1-59 month mortality reduction target



Today's speakers

Dr. Anne Detjen,
UNICEF New York

Dr. Tomomi Kitamura
UNICEF WCARO

Dr. Sartie Kenneh
Chief Medical Officer
MoH Sierra Leone

Dr. Lynda Farma-Grant, Child Health Programme Manager, MoH Sierra Leone

Dr. Vandana Joshi
UNICEF Sierra Leone

Dr. Donald Grant
District Health Manager,
Kenema, Sierra Leone

NATIONAL CHILD HEALTH PROGRAMME, MINISTRY OF HEALTH

Operationalizing the Sierra Leone Child Survival Action Plan – the national perspective

Overview

Urgency to act

With a mortality rate of 94 per 100 live births in 2023, Sierra Leone needs to accelerate progress to achieving the child survival SDGs, focusing on both newborn and 1-59 month mortality alongside maternal mortality

Aligned under RMNCAH strategy

Action oriented

Life cycle approach and continuum of care with Maternal and Newborn health

In 2022, the MOH and Health Development Partners developed Sierra Leone's Child Survival Action Plan (CSAP) 2023-2025

The CSAP goal is to reduce under-five mortality to as low as 71 per 1000 births by 2025

The plan considered six critical bottlenecks to progress and defined priority actions with clear milestones and targets

Over the past 18 Months, the MOH and HDPs have been implementing the CSAP to reduce under-five mortality in the country

We have noted achievements, challenges, and opportunities in the implementation of the CSAP

From defining bottlenecks to targeted action

Bottlenecks

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

2. Lack of **quality data for child health**, including accountability and oversight for reporting and use across all levels

3. Poor adherence to norms, standards, and guidelines for care, due to weaknesses in **health worker competencies** at community, PHU and referral levels

4. Stockouts or unavailability of **essential child health commodities** at community, PHU and referral levels

5. Inadequate **community outreach and services** to promote care-seeking, prevent childhood illnesses, and treat children in hard-to-reach areas

6. Actual and potential role of **private sector** is not fully exploited

Targets

1. Create a Child Health Programme with costed annual workplan reporting monthly progress to Senior Management
2. Reconstitute Child Survival Technical Working Group
3. Establish Child Health Focal Points in districts to coordinate and regularly report progress,
4. 100% of districts with a functional MNCH TWG
5. 100% of districts provide monthly progress
6. 100% alignment of partner child survival plans
7. 80% of CSA budget funded by 2025,
8. Essential health service package for UHC implemented
9. At least 2 champions are supporting CSA advocacy including domestic financing
10. Revitalize and strengthen the already established child death audit dashboard
11. Include non-malaria iCCM commodities in the GC7
12. Leverage medical oxygen investments to ensure equipment and clinical capacity for hypoxemia management in children
13. By 2025, the Community Scorecard is used in all districts
14. Improve CHWs' ability to undertake home visits (through community health-focused grants)
15. Map private providers, establish MOU and referral system, and training

Achievements (I)

- CSAP **has elevated the child survival and wellbeing agenda** at the highest level of the MOH
- CSAP has high **visibility**, like maternal survival
- Elevated **momentum for acceleration** by partners and GOSL – **Emergency declaration** facilitated for further pushing the CSA agenda
- Strengthened national and sub-national **governance structure**
- Improved **partners' coordination** in the implementation of the child survival and well-being initiatives especially at National Level
- It has improved the **culture of counting each child's death**

Achievements (II)

- Establishment of a standalone **national child health programme** to provide oversight on child health and wellbeing initiatives, and coordinate within MoH
- Identification of **dedicated child health personnel** at the national level with clear TORs
- Appointment of dedicated hospital and district child health **focal points** with clear TORs
- Establishment of the **national child health TWG** with TORs and regular monthly meetings
- Developed national and district child health **workplans**
- **Tracer indicators** selected and reported (eg, IMNCI, ETAT, IMAM)

Achievements (III)

- Monthly progress update on Child Survival to MOH Senior Management
- Developed CSAP results framework
- Reviewed and revised the national HMIS data dictionary for child health indicators
- Further institutionalization of child death audits and quality improvements, including capacity building in selected hospitals
- Enhanced collaboration between the child health programme and Malaria, HIV, TB, EPI, and Nutrition
- Coordinated data for action training for child health focal points and M&E officers

Achievements (IV)

- Participate in the weekly emergency meeting
- Implementation of the CSAP in one District for evidence generation (Kenema)
- Dissemination of periodic bulletins
- Complete quantification data for Child Health commodities is available from all districts
- Close collaboration with the Paediatric Association
- Review meeting in March 2025 with ~200 stakeholders

Comprehensive, integrated approach to address cross cutting bottlenecks for maternal/newborn (EWENE) and child survival (CSAP)
– under the minister's vision for a life-stages approach

Priorities	Action steps to achieve the priorities
Enhance IMNCI/iCCM at PHC level by undertaking training, supportive supervision and mentorship of health facility staff	• Review and validate the national supportive supervision tools • Undertake regular supportive supervision and mentorship
Undertake bi-annually integrated RMNCAH+N supportive supervision at secondary, primary health care and community levels.	• Develop/review supervision tools • Undertake regular supportive supervision and mentorship
Undertake bi-annual RMNCAH+N performance Reviews using RMNCAH+N Scorecard and other tools.	• Update and populate the scorecard • Disseminate the scorecard

Progress overall against CSA milestones set in 2023 for Sierra Leone

Child Survival coordination platforms established, and child health focal points appointed at national and sub-national levels with clear TORs

Child Survival Action (CSA) priorities and essential service package popularized to all districts

Increased partner support for CSA Global Fund, Gavi, USAID, FCDO, World Bank, GFF, Irish Aid, JICA, GIZ, China AID, Islamic Development Bank, African development Bank, Foundations, etc

- 65% of activities funded
- Global Fund GC7 was used to support non-malaria commodities for used by CHWs

Critical Child Health indicators were included in the DHIS-2 and tracer indicators selected to capture reports on IMNCI/ICCM, integrated management of acute malnutrition (IMAM), Emergency Triage, Assessment & Treatment (ETAT)

Focal Points identified and trained to support quality Child Health data collection, analysis and use, including at hospitals

Child health death audits and monitoring introduced and used in all hospitals

All essential Child Health commodities, beyond malaria, were included during annual quantification process through regular TWG engagement with National Medical and Supply Agency (NMSA)

Child Health specific messages are regularly included in campaigns

>50% of districts provide monthly progress reports and recommendations on CSA through DMO/Child health focal persons (Kenema 100% adherence to monthly reporting)

Challenges

About 30-35% implementation rate

Partner plans are not always aligning with the MOH plan

District-level coordination and partner alignment not functional in all districts

Limited capacities of staff posted to the programme

No dedicated government funding to implement interventions listed in the CSAP

Implementation gaps remain, interventions not 'evenly scaled' across all districts (e.g. supervision, referral system, commodities),

Competing priorities across programmes

Frequent infectious diseases outbreaks

Shrinking donor support (USAID, FCDO)

No alignment with GF funding mechanisms

Opportunities

- Commitment of Partners National for CSAP Implemetation)
- Global Fund continued support to procure antibiotics
- End evaluation of the national RMNCAH strategy to broadly include the holistic child survival agenda in new strategy
- Antimicrobial resistance and antimicrobial stewardship programme
- Postgraduate education and Paediatric Mentorship Programme at SCBUs and Paed Wards in regional Hospitals
- Nutrition is high on the agenda at the level of the Vice President’s Office

Next Steps

- Review and extend the CSAP with some level of prioritization
- Inclusion of wellbeing components to the new CSAP- ECD Nurturing Care Framework
- Reviewed and Updated the IMNCI (now includes TB, ECD and Medical Oxygen) with its implementation nationwide and the introduction of dIMNCI
- Work with the PASL to develop modules on other priority disease affecting children e.g sickle cell disease
- Continued advocacy
- Continued resource mobilization and partner alignment for technical and financial support

Conclusion

CSAP has elevated child survival to the highest level at MOH

Established coordination platforms have been critical in the implementation of the CSAP

There is a need to accelerate CSAP implementation in Sierra Leone

A dedicated budget is required to ensure the comprehensive implementation of CSAP

Continued health development partners' technical and financial support is needed

Thank you!

Operationalizing Child survival action in Kenema District, Sierra Leone

MINISTRY OF HEALTH
GOVERNMENT OF SIERRA LEONE

unicef
for every child

Kenema District was chosen to be a learning district for operationalization of the CSAP

The district has

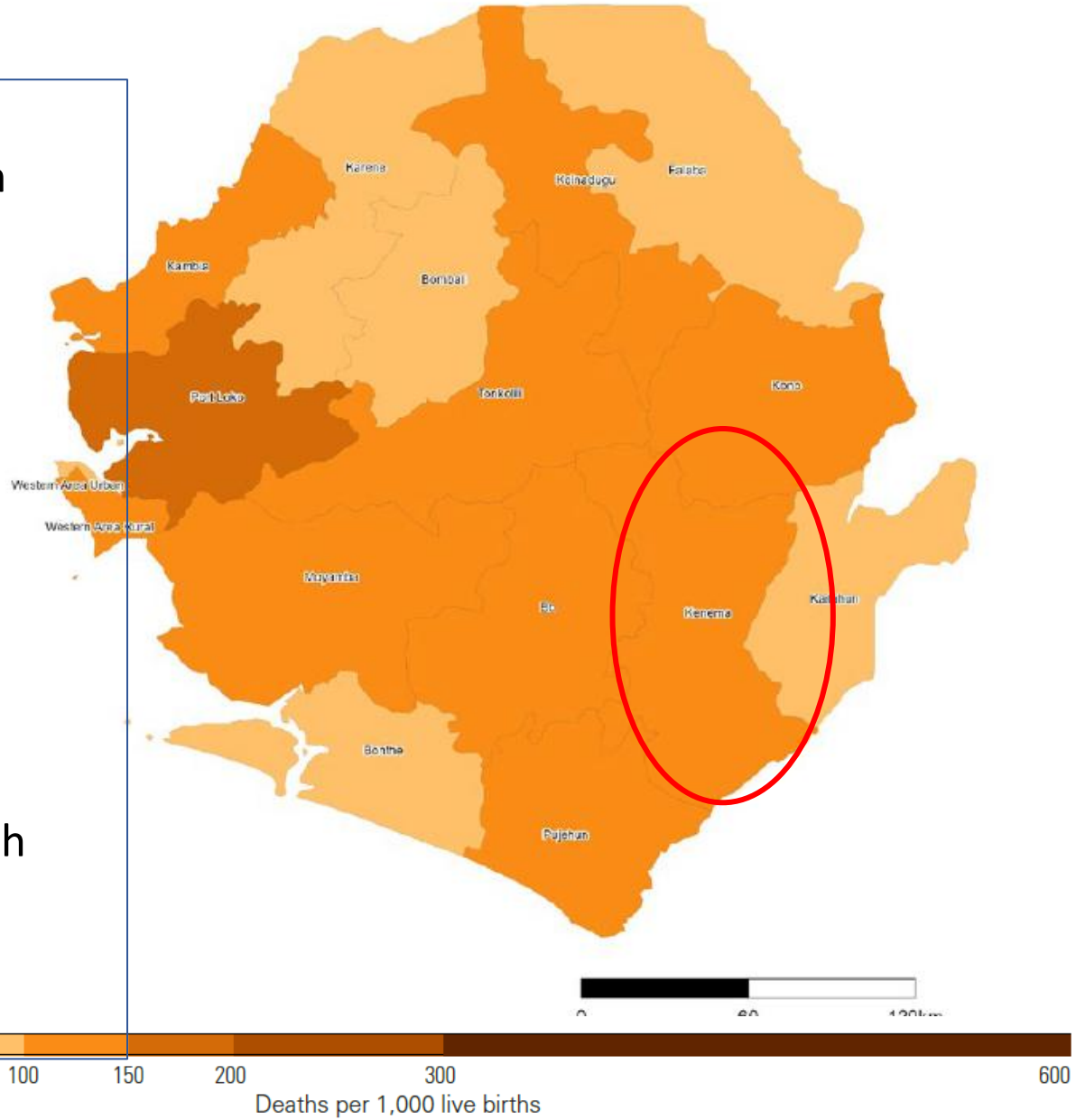
- 2nd highest total U5 pop (130,217), total population 735,692
- 2nd highest mortality rate (1-59 months) of (154.2) against the national average of 105 per 1,000
- 5th highest burden of zero dose children

Leadership and partnership

- Commitment and readiness from the DHMT
- UNICEF as partner with strategic funding support

Health infrastructure

- 125 PHC facilities (34 Community Health Centers, 33 Community Health Posts & 58 Maternal and Child Health Posts)
- 2 secondary hospitals
- 640 CHWs & 73 Peer Supervisor



In a snapshot: Key activities supported in Kenema across all six priority areas

Leadership and governance (engagement with partners)	➢ Subnational launch of CSAP, create conducive environment for regular reviews ➢ Set up mechanism for national level support for planning, monitoring, mentoring and oversight
Quality data and oversight for reporting & data use for decision making	➢ A Data Quality Assessment Tool for PHC developed with DPPI, MoH ➢ Training and mentoring on content and methods to do performance review across 16 key child health indicators

Enhance Health worker competencies and QoC	• Skills building (Focus on 34 community health centers and linked CHWs)
	  • Training PHU in-charges & peer supervisors on the WHO QI approach & Collaborative learning
	  • Facility and community HWs on IMNCI & iCCM (hard to reach) (305 staff trained first time)
	  • Established quarterly supportive supervision and mentoring

Stockouts of essential commodities across levels	• Build capacity of PHU in-charges on stock management and reporting • Improved last mile access through pre-packaging of commodities for CHWs providing iCCM • Increased buffer stock of Amox 250mg DT and ORS –Zinc, scaled pulse oximeters and O2 concentrators
Community outreach and community-based services	• Rollout of scorecards to increase transparency, accountability among community leaders and members of the community, health facility management and staff and local leaders and improve quality of care • Strong focus on CHWs as part of capacity building, for iCCM but also health prevention and promotion
Strengthening private sector engagement	Collaboration with councils, public private partnership for blood bank system and privately run 24 hr pharmacy

As a result...

Leadership and governance	➢ Continued government leadership on child survival under Deputy Minister ➢ Increased dialogue and common understanding among all actors on child survival priorities ➢ Technical working groups as platform for coordination, alignment, progress review and learning
Quality data including accountability and oversight for reporting and use	➢ Health facilities are equipped to monitor their own performance & identify gaps for quality improvement ➢ DHMT established mechanism for child death audits
Health worker competencies and QoC	➢ District health team has been skilled and equipped to conduct supervision, performance review and clinical mentorship for quality improvement, IMNCI and iCCM ➢ All 34 CHCs in Kenema have engaged in QI projects and reviewed milestones, and increased peer learning
Stockouts of essential commodities across levels	➢ Observed improvement in all 34 CHCs in tracking consumption of drugs and other medical supplies ➢ Pre-packaging of medicines for CHWs as scalable solution
Community outreach and community-based services	➢ Strengthened facility-community linkages ➢ Improved accountability mechanisms
Strengthening private sector engagement	➢ Public-private partnerships Kenema DHMT, councils and private partners to improve health infrastructure

Strengthening district level coordination

- **Dissemination meeting** to introduce the Child Survival Action Plan at District Level
- Nomination of **child health focal points** at district hospital and in DHMT
- **Establishment of a district level Technical Working Group**
  - Monthly meetings led by the District Medical Officer
- **Capacity building in management and leadership** of DHMT
  - DMHT demonstrated committed leadership to community health centers (CHCs) and empowered their capacity in planning and monitoring child health interventions to deliver quality care
  - CHC in-charges developed improved skills to better coordinate with other Primary Health Unit (PHU) staff to deliver effective child health service
- **Oversight and accountability**
  - National Child Health Programme (NCHP): regular monitoring visits during key events such as training, supervision and review meetings
  - MoH leadership, NCHP, other directorates and programmes (Reproductive and Child Health, EPI, Food and Nutrition, National Malaria Control Programme, PHC) conducted two program oversight and monitoring visits
- **Learning**: feedback on district level activities to National TWG

Skills building of healthcare workers and quality assurance

1. Training

305 PHU staff had bever been trained/equipped on IMNCI before

- 106 health workers in PHUs trained in IMNCI
- 259 CHWs including Peer Supporters in hard-to-reach areas trained in iCCM
- Additional focus on recognition of danger signs and prompt referral

2. Quarterly integrated supportive supervision and mentoring for IMNCI and iCCM

- Reaching 34 CHCs and linked CHWs
- 104 health workers and 104 CHWs were **directly observed** as they assess, classify and treat sick children
- 136 health workers and 227 CHWs were **coached based on the technical gaps identified** during the case observation and supervision

Sustainability consideration: DHMT has been equipped skills/expertise and tools to conduct IMNCI/ICCM and QI supervision, performance review and clinical mentorship.

Quality improvement: training, monitoring, action, and learning

Quality improvement skills enhanced of 34 CHC in-charges, CHW peer supervisors, 6 Kenema DHMT, 2 MoH staff, 2 district hospitals

- Training on WHO Quality Improvement (QI) approach and collaborative learning: 68 CHC in-charges and 34 Peer Supporters
- CHCs received monthly and quarterly QI supervision, monitoring and mentoring to review progress, identify issues and solutions through data driven QI decisions
- Peer learning and action support enhanced within 34 CHCs

All 34 CHCs in Kenema have engaged in QI projects and reviewed milestones related to ANC, IMNCI/iCCM, nutrition and EPI services

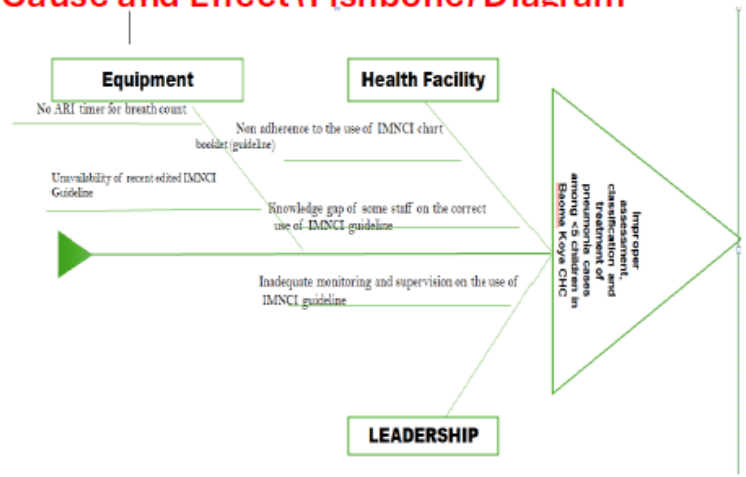
IMPROPER ASSESSMENT, CLASSIFICATION AND TREATMENT OF SICK <5 CHILDREN FOR PNEUMONIA AT BAOMA KOYA CHC

Background :, Baoma Koya CHC is located in Koya Chiefdom, Kenema District, with a catchment population of 7429 and serves Five(5) catchment communities. The facility comprises of eight(8) technical staff and four(4) Non technical staff, who render services in ANC, PNC, Labour and delivery, EPI, Growth monitoring and promotion, Family Planning, General morbidities (<5 & >5), Adolescent health, HIV, TB, EMTCT, Minor Surgeries and Outreach services.

Problem Statement : Facility Data reviewed from the IMNCI register from January- June, 2024 shows 6% baseline median for <5 sick children properly/correctly assessed, classified and treated for pneumonia cases using the IMNCI guideline/chart booklet at Baoma Koya CHC.
This low percentage of properly assessed, classified and treated sick <5 pneumonia cases has led to treatment failure, wastage and other complications, thereby resulting to an increase in deaths among this set of children.

Aim statement: Baoma Koya CHC aims to improve on the proper assessment, classification and treatment of pneumonia cases among sick under five children from a baseline median of 6% to 40% from July 1st to 31st December 2024.

Cause and Effect (Fishbone) Diagram



Facility Authors & contact information : Moinina F. Koroma-078551078

Interventions:

- Bi-monthly On the job training of facility staff on IMNCI guideline
- Enforced IMNCI chart booklet usage adherence among the facility staff
- Lobbied with DHMT child focal person for the availability of the updated IMNCI chart booklet at the facility

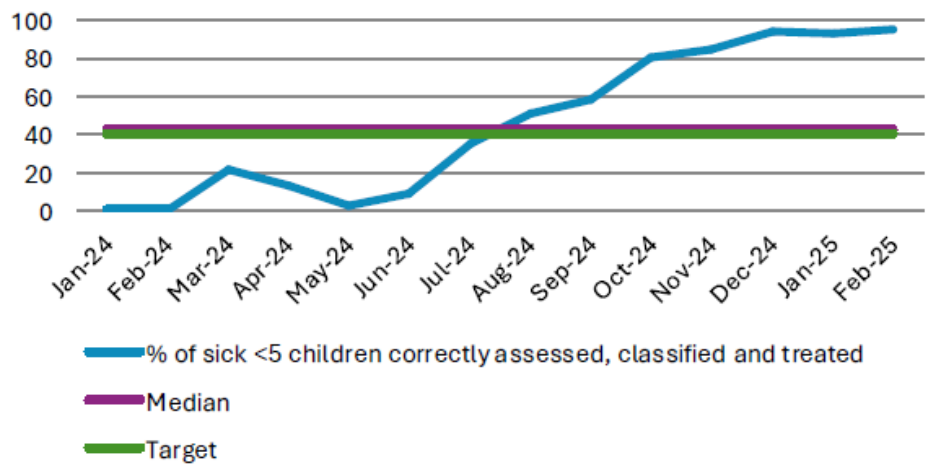
Strategy for change:

- Facility based training
- Guideline adherence
- Lobbying stakeholders

Measurement of improvement:

- % of facility-based training conducted.
- % of guideline adherence monitored.
- % of lobby sessions done.

Run chart showing correct assessment, classification and treatment of sick <5 children at Baoma Koya CHC from Jan 2024-Feb 2025



Effects of changes:

- Facility-based training on IMNCI guideline has enhanced staff knowledge, correct assessment, classification and treatment of <5 sick children for the past 8 months (July2024-Feb 2025).
- IMNCI guideline adherence has significantly improved patients health outcome, reduced child deaths and increased confidence of caregivers in the facility
- Awareness session on ANC medications: Increased client confidence in ANC drugs boosts adherence, leading to healthier maternal outcomes.

Lessons learnt:

- Adherence to guideline usage can significantly improve health outcome.
- Regular supportive supervision yields more learning.

Strengthening supply chain management

34 PHU in-charges were trained and capacity on stock management, documentation, distribution, rational use and reporting

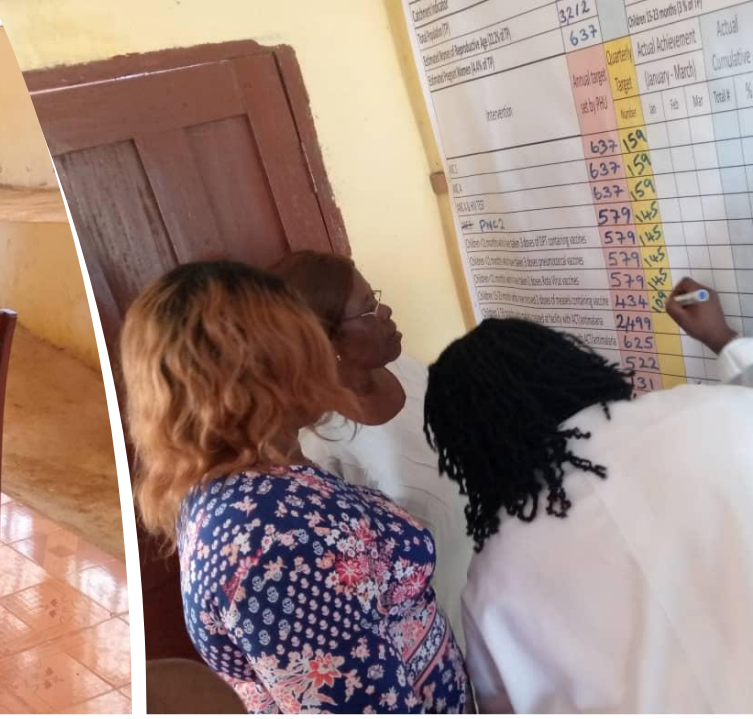
- Relevance of rational use of essential child health medicines used in IMNCI and iCCM
- Capacity enhanced to correctly fill LMIS (inventory control cards, monthly facility report/RRIV for FHC and daily dispensary register) and to ensure monthly submission

Tracking consumption of drugs and other medical supplies improved in all 34 CHCs

Increase buffer stock and address supply gaps

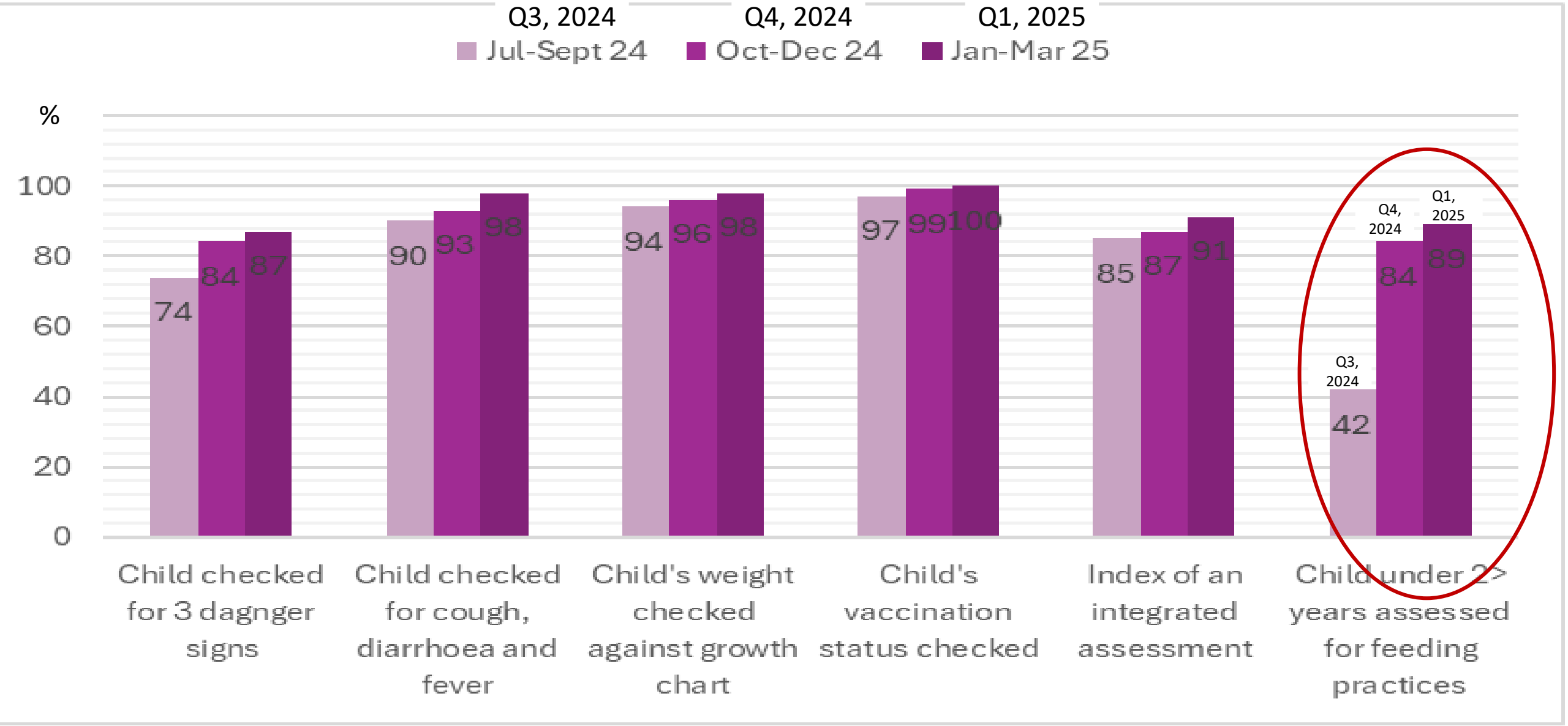
- Procurement of buffer stock: Amoxicillin dispersible tables and ORS –Zinc co-packs
- Ensuring availability at the last mile: prepackaging of iCCM commodities for 100 CHWs serving hard to reach areas
- Closing access gaps:
  - Ensuring availability of training materials, job aids and ARI Timers at 34 CHCs facilities and for CHWs
  - 5 CHCs were provided with pulse oximeters and oxygen concentrators, district hospital received oxygen plant

Improving data use: Planning, monitoring and evaluation

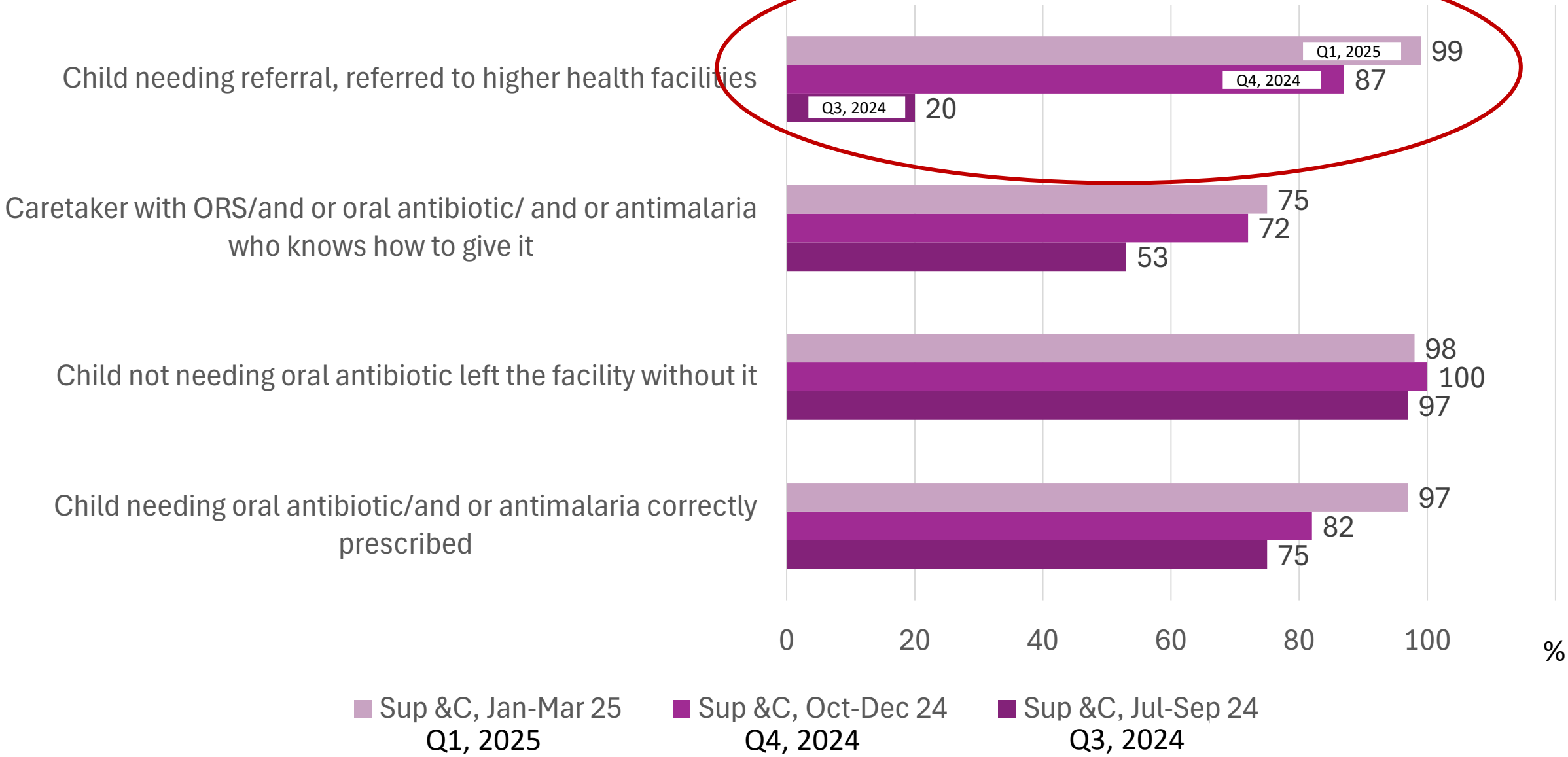


- Quarterly evidence-based performance review and planning meetings conducted at district level with CHC in-charges
  - Training and mentoring on the content and methods for performance review using 16 key performance indicators
  - 3 rounds of review, supervision and mentoring undertaken for 34 CHC facilities using performance monitoring chart
- Introduction of a **performance monitoring chart** at PHUs
  - Informed QI review and action
  - used to monitor quarterly coverage and progress to inform decision making

Quality of care in PHC facilities: **Assessment** of sick children **directly observed** using National IMNCI protocol for Quarters 3 and 4, 2024, and Quarter 1, 2025



Quality of care: **Treatment** provided to sick children **directly observed** using National IMNCI protocol for Quarters 3 and 4, 2024, and Quarter 1, 2025



Strengthening the continuum from community to referral level

DHMT established a mechanism for weekly child death audits, identifying the events which led to death including delay in timely care-seeking and referrals

Ongoing review

Political Leadership attending review

Community Engagement and participation

Lessons learnt in Kenema

- Collection and use of quality data for child health, including accountability and oversight for reporting were enhanced and improved
- The performance monitoring chart is welcomed and sued by CHC in-charges.

- Adherence to protocols and quality of services can be strengthen through regular supervision and mentoring (targeting low-performing facilities or addressing specific issues e.g. identification and referral for danger signs)
- Promoting effective peer learning among nurses is key to improving the quality of services

- Improved coordination at district level and accountability from national level
- DHMT has established a mechanism for weekly child death audits identifying the events which led to death including delay in timely care-seeking and referrals

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

Lack of **quality data for child health**, including accountability and oversight for reporting and use across all levels

Poor adherence to norms, standards, and guidelines for care, due to weaknesses in **health worker competencies** at community, PHU and referral levels

Stockouts or unavailability of essential **child health commodities** at community, PHU, and referral levels

Inadequate **community outreach and services** to promote care-seeking, prevent childhood illnesses, and treat children in hard-to-reach areas

Actual and potential role of **private sector** providers is not fully exploited

Skills building in stock management and prepackaging for CHWs reduces stockouts

- Well trained and supported CHWs are an important link between communities and facilities
- Community leaders and members are critical partners

- Public private partnerships can help to address gaps

Critical gaps that require continued focus and support

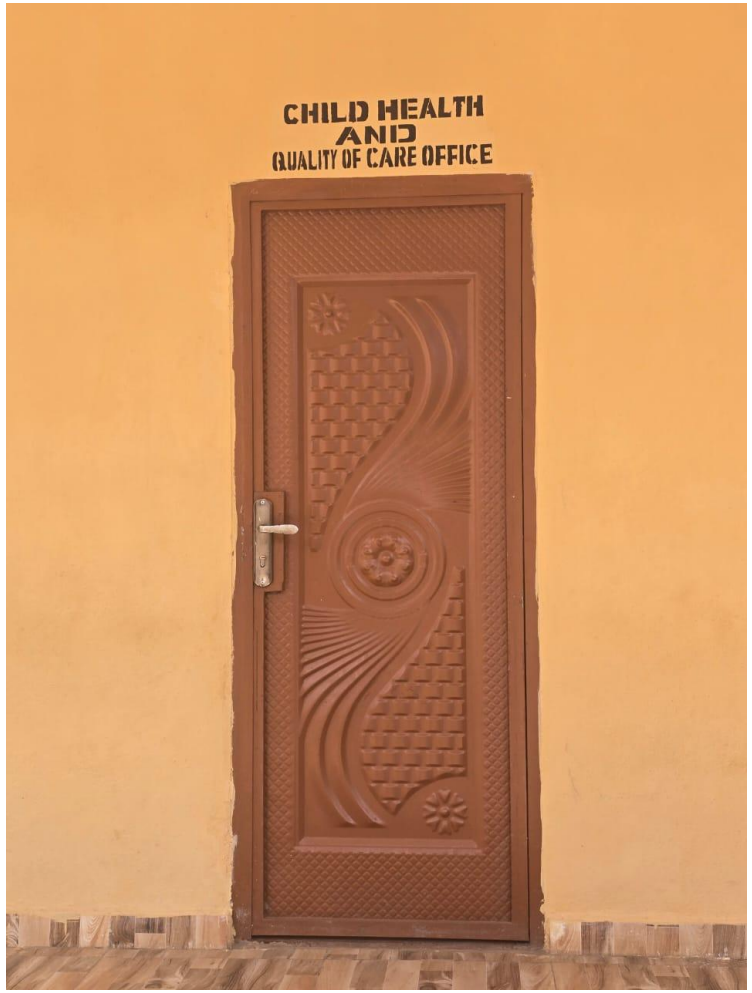
Leadership and governance	Build on lessons learned and best practices to sustain and further scale in Kenema, and in other districts
Quality data including accountability and oversight for reporting and use	Institutionalize and scale the use of data for decision making and systematic quality improvement
Health worker competencies and QoC	Continue and scale regular supportive supervision and mentoring Quality improvement -Scaling and sustaining support to all CHCs and CHWs – identifying those that need to be prioritized for QI Retention of CHWs after training
Stockouts of essential commodities across levels	Further address supply chain bottlenecks to avoid future stockouts

Issues that were not a key focus of the activities and require further attention

- **The referral system** is weak, causing significant delays
- **Hospital level care of sick children:** in-patient care for sick children needs strengthening alongside small and sick newborn care(human resources, equipment, skills, documentation and performance monitoring)

Forwarding Thinking in Kenema

Establishment of Child Health Office at DHMT



Donation of Motor bikes

Thank you

Kenema District, May 2024