



GOVERNMENT OF SIERRA LEONE

HEALTH COMPACT

December 2011

TABLE OF CONTENTS

| | |
|---|-------|
| GLOSSARY | p. 3 |
| 1. INTRODUCTION | p. 4 |
| 1.1 Background and purpose of Compact..... | p. 4 |
| 1.2 Definitions..... | p. 5 |
| 2. GUIDING PRINCIPLES | p. 5 |
| 3. PREAMBLE | p. 6 |
| 4. COMMITMENTS BY THE GOVERNMENT OF SIERRA LEONE | p. 7 |
| 5. COMMITMENTS OF THE HEALTH DEVELOPMENT PARTNERS | p. 7 |
| 6. COMMITMENTS OF IMPLEMENTING PARTNERS | p. 8 |
| 7. JOINT WORKING ARRANGEMENTS | p. 8 |
| 7.1 Ownership, Leadership and Governance..... | p. 8 |
| 7.1.1 Policy environment..... | p. 8 |
| 7.1.2 MOHS Structure..... | p. 8 |
| 7.1.3 National Coordination Mechanisms..... | p.9 |
| 7.1.4 District Coordination..... | p.9 |
| 7.2 Planning, budgeting and implementation..... | p. 9 |
| 7.3 Procurement and supply-chain management..... | p.10 |
| 7.3.1 Interim Arrangements..... | p. 11 |
| 7.4 Health financing and financial management system..... | p. 11 |
| 7.4.1 Health Financing..... | p. 11 |
| 7.4.2 Funding modalities..... | p. 11 |
| 7.4.3 Accounting and Financial Reporting..... | p. 12 |
| 7.4.4. Audit..... | p. 12 |
| 7.5 Monitoring, evaluation and supervision..... | p. 12 |
| 7.6 Human resource for health..... | p. 12 |
| 7.6.1 Technical assistance..... | p. 12 |
| 8. PREVENTION AND SETTLEMENT OF DISAGREEMENTS AND CONFLICT | p. 13 |
| 9. AMENDMENT/TERMINATION | p. 13 |
| 10. INCLUSION OF NEW PARTNERS | p. 13 |
| 11. DATE OF EFFECTIVENESS | p. 14 |
| 12. SIGNATORIES | p. 15 |
| Annex 1: Coordination Mechanism..... | p. 18 |
| Annex 2: IHP+ Development Partners standard performance measures..... | p. 19 |
| Annex 3: IHP + GoSL Standard Performance Measures..... | p. 20 |

GLOSSARY

| | |
|--------|--|
| AOP | Annual Operating Plans |
| FBO | Faith-Based Organizations |
| FHCI | Free Health Care Initiative |
| GoSL | Government of Sierra Leone |
| HDP | Health Development Partners |
| HSCC | Health Sector Coordinating Committee |
| HMIS | Health Management Information System |
| HSSG | Health Sector Steering Group |
| IMP | Implementing Partners |
| ISDWG | Working Group on Integrated Service Delivery and Associated Supportive Supervision |
| LMIS | Logistics Management Information System |
| LGWG | Working Group on leadership and Governance |
| MDG | Millennium Development Goals |
| MoHS | Ministry of Health and Sanitation |
| MoFED | Ministry of Finance and Economic Development |
| MTEF | Medium-term expenditure framework |
| NGO | Non-Governmental Organization |
| NHSSP | National Health Sector Strategic Plan |
| ODA | Overseas Development Aid |
| PIU | Project Implementation Units |
| PETS | Public Expenditure Tracking Surveys |
| SLeSHI | Sierra Leone Health Insurance Scheme |

SIERRA LEONE HEALTH COMPACT

1. INTRODUCTION

1.1 BACKGROUND AND PURPOSE OF COMPACT

A National Health Policy developed in 2002 and revised in 2009 has provided an environment for health reconstruction followed by the current development. The Government of Sierra Leone in consultation with partners has developed a 6-year National Health Sector Strategic Plan (NHSSP), which provides the framework for improving the health of the nation. The implementation of this plan will require concerted effort from all stakeholders in the health sector.

As part implementation of NHSSP and the government's Agenda for Change, the free health care initiative was launched in 2010 realising tremendous results with regard to enhancing access for the target population. Sustainability of this initiative raised concerns and became the key justification for aid effectiveness and resource utilisation efficiency through a country compact.

This Compact sets out understandings reached between the Government of Sierra Leone (GoSL) and health partners who are signatories to it. The main objective is to set out a framework for increased and more effective aid, in order to permit Sierra Leone to make faster progress towards achieving the goals of the 'Agenda for Change' for Health and Health Millennium Development Goals (MDGs).

This Compact is intended to guide all health partners working in Sierra Leone. This Compact provides a framework for adherence by all partners to the principles and approaches set out in the global IHP Compact, which reflects the goals of the Paris Declaration.

1.2 DEFINITIONS

In this document the following terms are defined as:

- I. *The Government of the Republic of Sierra Leone (GoSL)* means the entire apparatus of Government and its institutions, represented in the context of this Compact by the Sierra Leone Ministry of Health and Sanitation (MoHS), the Ministry of Finance and Economic Development (MoFED) and the Ministry of Local Government and Rural Development.
- II. *The Sierra Leone Health Sector Compact* is the voluntary agreement between the GoSL and its partners in health development that guides the ways of doing business in their joint and coordinated effort to implement the National Health Sector Strategic Plan (NHSSP) 2010-2015 through a sector-wide approach that places greater emphasis on accelerated scaling-up of priority health interventions for maximum health impact on its MDG targets, and on mutual accountability.
- III. *The Paris Declaration* contains partnership commitments aimed at improving the effectiveness of aid for sustainable development and is focused on five mutually reinforcing principles:
 - *Ownership*: Developing countries must lead their own development policies and strategies, and manage their own development work on the ground. Donors must support developing countries in building up their capacity to exercise this kind of leadership by strengthening local expertise, institutions and management systems.
 - *Alignment*: Donors must line up their aid firmly behind the priorities outlined in developing countries' national development strategies. Wherever possible, they must use local institutions and procedures for managing aid in order to build sustainable structures. Where these systems are not strong enough to manage aid effectively, donors would strengthen them including improving predictability and progressively "untying" aid.
 - *Harmonisation*: Donors must coordinate their development work better amongst themselves to avoid duplication and high transaction costs for poor countries. Aid is pooled in support of a strategy led by a recipient country - a national health plan – rather than fragmented into multiple individual projects.
 - *Managing for results*: All parties in the aid relationship must place more focus on the end result of aid, the tangible difference it makes in poor people's lives. They must develop better tools and systems to measure this impact.
 - *Mutual accountability*: Donors and developing countries must account more transparently to each other for their use

of aid funds, and to their citizens and parliaments for the impact of their aid.

- IV. *Health Partners* are all stakeholders active in the health sector i.e. the Government, bilateral and multilateral agencies, civil society organisations, local and international NGOs and the private sector.
- V. *Health Development Partners* (HDP) is used in this document to include each and all of external Governments, bilateral agencies, multilateral agencies, funding foundations and global/regional health initiatives that are committed to working together and with the GoSL in a joint effort to support the funding, whether in pooled or non-pooled funding arrangements, and management of the implementation of the GoSL NHSSP and Annual Operational Plans (AOPs). HDPs that are signatory to this Code of Conduct are listed at the end of this document.
- VI. *Implementing Partners* (IMP) means the various non-public sector partners that implement or support implementation of health plans and activities in collaboration with the Ministry, Local Councils and/or communities in Sierra Leone

2. GUIDING PRINCIPLES

The basic principles that will guide the partnership under this Compact are:

- I. National Ownership with the GoSL exercising leadership in the development and implementation of the NHSSP, as well as in the effective functioning of the common working arrangements jointly agreed upon - through broad and meaningful consultation processes.
- II. Accountable governance and provision of accessible, effective, efficient and responsive local health services.
- III. Mutual Accountability for programme results, as well as for level of compliance of partners with the commitments made under this Compact.
- IV. Managing for Results through a transparent and monitorable performance assessment framework to (a) assess progress against the national development strategies and (b) sector programmes.
- V. Appropriate devolution of decision making and priority setting to Local Councils in line with the decentralisation policy of GoSL
- VI. One development framework (NHSSP), one results framework, one budget process, one fiduciary risk-management framework, one monitoring and evaluation framework, and one reporting.
- VII. Supporting National Capacity development (including human resources development) by using the country's own institutions, systems and processes, with additional transitional safeguards where necessary, while strengthening the country's own systems for long term sustainability.
- VIII. Affirmative action geared towards increasing access to quality health care by the poor and other vulnerable groups.
- IX. Integrating human rights, gender, equity, equality environmental protection and good governance.
- X. Broadening the base of the partnership through wider engagement with other health-related sectors of government and the non-public sector actors (such as civil society, private sector), health statutory bodies and training institutions, and Academia.

3. PREAMBLE

This Health Sector Compact, made the 27th of April, between the Government of the Republic of Sierra Leone (GoSL) represented by its Ministry of Health and Sanitation, the Ministry of Finance and Economic Development and the Ministry of Local Government and Rural Development (hereinafter referred to as the GoSL) of the one part and health partners on the other part:

WHEREAS the GoSL is desirous of implementing the NHSSP 2010-2015 with the objective of accelerating the scaling-up of the priority evidence-based health interventions that would bring Sierra Leone on track for achieving its MDG Targets;

WHEREAS the GoSL and health partners are committed to the Principles of the Paris Declaration, the 2008 Accra Agenda for Action and the IHP+ Global Compact;

WHEREAS the health partners are committed to adopting an approach which will address the health sector as a whole in planning,

financing, implementing, monitoring, evaluating and reporting;

WHEREAS all health partners signatory to this Compact are committed to implement the NHSSP, in which policy development, planning, financing, implementing, reviewing, monitoring, evaluating and reporting are carried out as joint effort through consultation;

WHEREAS all health partners are committed to supporting, regular reviewing, and updating the NHSSP and are aware that this Compact:

- a) does not constitute a legally binding instrument, but reflects the voluntary commitment of all health partners working in Sierra Leone
- b) does not supersede the legally binding agreements between the GoSL and any of the health partners, or the laws, regulations and policies of the GoSL or the health partners; and where there is a conflict between this Compact and any legally binding agreement or law, regulation or policy, the terms of the legally binding agreement, law, regulation or policy will govern. In the event of conflict between specific provisions of bilateral agreements of health partners and the Compact, the health partners concerned will inform the signatories about the discrepancies. All health partners should be committed to reduce these exceptions over time
- c) reflects a commitment to shared ownership and responsibility for the degree of success achieved in reaching the stated health sector goals, objectives and targets
- d) shall guide, regulate, and monitor the operation of the partnership in working towards achieving the health outcomes and impact targeted in the NHSSP and MDGs

NOW THEREFORE all Partners are committed to the following:

4. COMMITMENTS BY THE GOVERNMENT OF SIERRA LEONE

The Government of Sierra Leone acting within its general policies and legislation is committed to:

- I. Assure that all the structures and systems developed jointly for the operation of the partnership under this Compact are functioning effectively and in accordance with the schedules laid down.
- II. Provide overall leadership in the joint target-setting, planning, budgeting, monitoring, evaluating and reporting on the implementation of the NHSSP and its AOPs and budgets. This should include the improvement of accountability to the citizens by the implementation of service charter.
- III. Ensure that the proportion of the overall GoSL annual budget allocated to the health sector increases annually and in accordance with PRSP and the Abuja Declaration (15% of GDP).
- IV. Ensure that all overseas development assistance, including extra-budgetary resources are additional to GoSL projected commitments for the sector within the Medium-term expenditure framework (MTEF). In this regard, GoSL through its MoFED will at the commencement of each budget development cycle, clarify its position with regard to funding for the health sector.
- V. Publish in its Annual Health Sector Performance Report the proportion of total annual Overseas Development Aid (ODA) for the sector including support from non-signatory partners that is: (a) provided on budget, (b) fully aligned with NHSSP, and (c) provided through a sector pooling arrangement. And ascertain through its MoFED that resources allocated to the health sector by partners are captured as much as possible in the MTEF and annual budgets.
- VI. Notify all partners in a timely manner of negotiations between GoSL and any development partners that have a bearing on this partnership, its Compact or the NHSSP and its AOPs through the Health Sector Coordinating Committee (HSCC).
- VII. Coordinate all central MoHS and Local Council health plans, as well as ensure that the Local Council planning processes are linked to and inform the consolidated national health operational plan. GoSL will also see to it that all programmes and projects supported by development partners are aligned with the NHSSP, AOP and MTEF.
- VIII. Where appropriate foster and support expanded public-private-partnerships in health, including adopting appropriate modalities

ties for supporting implementing partners and performance-based financing.

- IX. Ensure that funds provided are exclusively used for financing approved activities and that there is timely and effective quarterly performance monitoring and reporting to provide financial and performance information according to jointly decided formats.
- X. Develop, in consultation with all the other partners, effective and equitable modalities for supporting the various constituencies of implementing partners, using the financial and material resources mobilised.
- XI. Work closely with all partners to integrate progressively all existing parallel health sector Project Implementation Units (PIUs) operating in the country and to absorb them into the working arrangements of a re-structured MoHS.
- XII. Ascertain that any proposed changes in the jointly agreed framework of this Compact are discussed with all other partners through the consultative processes and structures spelt out in this Compact.
- XIII. Inform all partners of any adverse circumstances which might threaten the accomplishment of the commonly set goals and objectives.

5. COMMITMENTS OF THE HEALTH DEVELOPMENT PARTNERS

The Health Development Partners are committed, within their general policies and legislation to:

- I. Respect the ownership and leadership of GoSL of the partnership and this Compact, and help to support national capacity development to enable it to fulfil this role.
- II. Use the NHSSP and AOP (which includes the district plan) as the framework for their support to the health sector and to align their country policies, strategies, plans and financing with national strategies, plans and budgets and avoid creation of parallel structures.
- III. Align their own planning, financing, budgeting, review, monitoring, evaluation, and reporting systems and processes with those systems, procedures and processes established for implementation of the NHSSP.
- IV. Negotiate with the MoHS all new programmes or initiatives pertaining to health and health services to be implemented in the country before finalizing bilateral agreements with MoFED and/or implementing partners.
- V. Ensure that support to the health sector is moving increasingly to be untied, has long term commitment, predictability of resource flow, strategies of financial sustainability, continuity of implementation and exit strategies.
- VI. Ensure that financial information on all grants, credits and other disbursements, including details of procurement and technical assistance, are provided quarterly to the MoFED and MoHS in an agreed format, so that they may be reflected in the plans and budgets of the GoSL. Any changes to programmes and/or funding should also be communicated to all partners within a quarter.
- VII. Establish internal coordination mechanisms and structures to facilitate their dialogue with the GoSL and other development partners in line with good practice as described in the Paris Declaration and the Accra Action Plan.
- VIII. Where use of any particular current GoSL system is not feasible, establish jointly with the GoSL, additional safeguards and measures in ways that strengthen rather than undermine the country's systems, processes and procedures.

6. COMMITMENTS OF IMPLEMENTING PARTNERS

All participating Implementing Partners will:

- I. Organize themselves into distinct and fully representative umbrella organizations or constituencies (e.g. Faith-Based Organisations (FBOs), Non-governmental Organisations (NGOs), private clinics, private enterprises, etc.) for purposes of interacting with other stakeholders within the health partnership in the context of this Compact.
- II. Participate fully in the various governance and technical committees and working groups of the partnership including Health Sector Coordination Committee (HSCC), through formally designated representatives of constituencies as may be prescribed by the HSCC.

- III. Hold such designated members of constituencies responsible for dissemination of decisions and other information from HSCC and its structures, as well as to undertake the necessary consultation within the constituency so as to be able to represent the views and position of the constituency at the partnership consultative forums.
- IV. Ensure that all implementing partners' programs and plans, irrespective of source of funding, are consistent with the NHSSP and the integrated AOPs for the MoHS and/or Local Councils.
- V. Consult with central MoHS when engaging in negotiations with Development Partners on health matters with national scope and with the DHMTs for matters related specifically to local councils and community level plans, programs and activities.
- VI. Ensure that there is prior consultation with central MoHS on the selection of local council areas which must be supported based on needs, equitable access and distribution of health services across the country.
- VII. Ensure that their health programs are aligned with and included in the health plans of the relevant local councils or municipalities.
- VIII. Ensure that they renew their operations in accordance with the NGO policy.
- IX. Disclose freely, all support being received or solicited for health activities using an accepted format (including source of funding, amounts, purpose, duration, geographical area, etc.) for their programs, for inclusion in the health sector resource envelope.
- X. Enter into formal service level performance-based contracts or agreements with the MoHS, local councils or DHMT when these are introduced.
- XI. Report regularly on a quarterly basis on financial and technical performance in accordance or consistent with the GoSL reporting and monitoring systems and formats.

7. JOINT WORKING ARRANGEMENTS

7.1 OWNERSHIP, LEADERSHIP AND GOVERNANCE

7.1.1 Policy Environment

The health sector is guided by the National Health Policy. The National health policy should provide a clear direction for the workings of the entire health sector. The current policy will be reviewed by all health partners and revised to ensure that it is fully consistent with the health objectives of the President's Agenda for Change. This revision will occur in 2011.

7.1.2 MOHS Structure

The current structure and functioning of the MoHS have revealed areas of overlap and lack of clarity in both responsibilities and lines of reporting and accountability. An internal restructuring exercise has therefore been scheduled for the first half of 2011. Meanwhile, interim lines of accountability to guide the operational arrangements of the Ministry are in place.

Effective as of the first quarter 2011, communication and reporting within the MOHS will be strengthened and internal coordination reinforced.

7.1.3 National Coordination Mechanisms

Guidelines and Terms of Reference (TOR) of the coordination mechanism will be produced to facilitate their functioning, however below is a summary of the roles and responsibilities of each structure (also see Annex 1):

- The *Health Sector Coordination Committee* (HSCC) is the highest consultative and strategic decision making body in the sector. The Minister of Health will chair HSCC with the Deputy Minister as Vice Chair against the agreed TOR and in line with indicated membership including the CCM and National AIDS Secretariat.
- The Free Health Care Initiative (FHCI) Steering Group will have its mandate expanded to cover the entire HSSP and will henceforth be called the *Health Sector Steering Group* (HSSG), chaired by the Chief Medical Officer (CMO). The current sub-committees of the FHCI Steering Group will also be restructured to reflect the main pillars of HSSP and the needs of the

Country Compact. The sub-committees will now become the *Health Sector Working Groups* (WGs) and the existing TOR for each WG will be updated to reflect this. Whenever necessary, WGs may set up ad hoc joint sub-committees or task teams to address issues that cut across their respective mandates.

The following represents the configuration of the Health Sector Working Groups:

- I. *Working Group on Leadership and Governance* (LGWG) - this WG will handle all issues related to the Government's leadership role; overseeing the functioning of the partnership structures and working arrangements and the planning and budgeting process.
- II. *Working Group on Integrated Service Delivery and Associated Supportive Supervision* (ISDWG) - This WG will be responsible for the coordination of the integrated delivery of the Basic Package of Essential Health Services (BPEHS) including the referral chain and supportive supervision to ensure effective service delivery at all levels including community. It will be responsible for strategic guidance in the selection of the most appropriate and effective interventions in each of the technical programme areas. This working group will also build on the work being undertaken by the Ministry of Health and Sanitation and the Ministry of Agriculture, Forestry and Food Security and promote preparation of an integrated implementation plan on nutrition within the context of the Government of Sierra Leone's Food and Nutrition Policy, through a nutrition-focused sub-working group that brings together stakeholders and coordinates efforts to enhance implementation at all levels.
- III. *Working Group on Human Resource Development and Management* - This WG will look at workforce planning for the immediate, medium and long-term including planning for up-skilling of existing staff and the training of new staff as per the needs in the country against the resources (current and projected) available. It will also propose innovative means of improving recruitment, deployment and retention of required skills including the development of Integrated Human Resource Information System (IHRIS).
- IV. *Working Group on Health Infrastructure Development and Maintenance* - this WG will be responsible for civil works, utilities, transport, equipment, preventive maintenance of buildings and equipment, development of the medium and long term health infrastructure development and maintenance plan.
- V. *Working Group on Health Financing and Financial Management* - this WG will spearhead the implementation of the national Health Financing Policy, Strategy and Plan. Responsibilities will also include collaborating with MoFED and the Ministry of Local Government and Rural Development in the strengthening and supporting central and district financial management systems.
- VI. *Working Group on Procurement, Supply Chain Management, and Medical Products and Technology* – this WG will plan and oversee the implementation of the short, medium and long-term strategies and plans for public procurement and supply-chain management systems including Logistics Management Information System (LMIS) and the related capacity development programmes example.
- VII. *Working Group on Health Information, M&E and associated Supportive Supervision* – This WG will be overall responsible for the Health Management Information System (HMIS) and Logistics Management Information System (LMIS) development and strengthening, including supportive supervision for their effective implementation.

7.1.4. District Coordination

Similar governance arrangements as at the central level will be put in place at the district to the ward level. Communication and reporting systems at Local council and central level will be strengthened. The MoHS will work closely especially with the Ministry of Local Government and Rural Development to develop the capacities of these structures and mechanisms.

7.2 PLANNING, BUDGETING AND IMPLEMENTATION

Implementation of NHSSP will follow the GoSL planning and management systems. Sector-wide planning, implementation and supervision of Annual Operational Plans (AOPs) will be jointly undertaken by all health partners following the GoSL planning cycle and processes in the context of the programme of work as in Table 1 on page 11. All partners will commit themselves to the health sector operational plans. This will ensure the process is transparent, bottom up and evidence-based with clear time frames for inputs. Both Government and partners will provide the indicative budget ceilings or actual budget allocations (where possible) in

June/July.

Table 1: Planning Cycle Timeline

| # | ACTIVITY | TIMELINE |
|----|--|---------------------------|
| 1 | District quarterly progress review and planning for the next quarter | January |
| 2 | Internal Annual Health Sector Performance Review | February |
| 3 | District quarterly progress review and planning for the next quarter and development of AHSPR Report | April |
| 4 | Annual Independent External Performance Review | April |
| 5 | Provision of Planning Formats, Guidelines, | April |
| 6 | Annual Health Review Summit | June |
| 7 | HSCC approval and distribution of AHSPR Report | July |
| 8 | Release of GoSL and HDP indicative Budget Ceilings | June/July |
| | Confirmation of HDP Pledges and firm figures | July |
| 9 | District quarterly progress review and planning for the next quarter | July |
| 10 | Development of LC and Central level AOPs and Budgets | Completion mid- September |
| 11 | Consolidation of LC and Central MoHS AOPs | Early October |
| 12 | Review of draft Consolidated Plans and approval of budget by HSCC | Mid October |
| 13 | Submission of Budget proposals to MoFED | Mid October |
| 14 | District quarterly progress review and planning for the next quarter | October |
| 15 | Review of Approved Budget by Planning Summit and update of the 3-Year rolling Programme of Work | November |
| 16 | 3 Year rolling Programme of Work's approval by HSCC | December |

7.3 PROCUREMENT AND SUPPLY-CHAIN MANAGEMENT

The GoSL through its MoHS and local councils is responsible for the provision of health services to the people of Sierra Leone. In order to fulfil this responsibility, the MoHS and local councils procure a range of works, goods and services through government systems particularly for those citizens that are covered by the Cost Recovery programme (i.e. approximately 80% of the population outside the 20% that are direct beneficiaries of the FHCI). There are also many different parallel systems and processes currently in operation using multi-lateral partners (all those who are working in the health sector- definition). Split procurement is common, with over 70 separate departments, programmes, projects and units undertaking their own procurement using parallel systems. This wide range of procurement systems causes logistical and coordination problems for GoSL, especially in the procurement of medicines, diagnostics and other health consumables.

In 2002, the GoSL commissioned a review of the system which resulted in the National Pharmaceutical Procurement Unit (NPPU) draft cabinet paper and draft NPPU Statute 2004. This was followed by an EU funded project to construct physical facilities of the Central Medical Stores (CMS) and District Medical Stores (DMS) and to develop proposals for the establishment of an Autonomous Pharmaceutical Procurement and Supply Agency (APPSA) with the purpose of centralising the procurement of medicines and related consumables for the entire country. The concept to establish the agency was approved by MoHS. Currently, the establishment of the new autonomous entity is going through the final stages of consultation with Parliament. The new APPSA body is envisaged to be in place by December 2011, subject to it passing through Parliament successfully.

Procurement of works and services will be in accordance to government rules and regulations.

7.3.1 Interim Arrangements

GoSL will continue using the current two-track approach for the immediate and short term while the capacity development package for the MoHS procurement unit is implemented and the autonomous procurement entity is instituted in 2011 (subject to parliamentary approval). This means that in the immediate and short term, GoSL will continue to use government systems as well as those systems that are well-established within key partners e.g. UNICEF, UNFPA and the ADB for procurement. Both processes will have clear timeframes and benchmarks for the progressive transfer of procurement, storage, and distribution responsibilities which will be clarified in a programme plan that is to be developed in conjunction with funding and implementing partners.

7.4 HEALTH FINANCING AND FINANCIAL MANAGEMENT SYSTEM

7.4.1 Health Financing

The GoSL has adopted the following approaches to broadening the financing base of the health sector, including:

- a) Critically reviewing the Drug Revolving Fund (for non-Free Health Care medicines and expendable supplies) with a view to instituting full accountability for supplies and cash receipts as they should be feeding into the overall health sector resource envelope.
- b) Establish the Sierra Leone Social Health Insurance scheme (SLeSHI) so as to provide a sustainable source of financing for the health sector
- c) Conduct National Health Accounts (NHA) every two years to guide policy and planning
- d) Identify other potential funding sources that complement Government's resources in order to sustain existing strategies and policies.

7.4.2 Funding modalities

- I. *Un-earmarked Sector Budget Support* is the preferred funding modality; however other funding mechanisms may be used in the interim so long as they are aligned with the NHSSP and its MTEF and AOPs.
- II. *A single central Pool* or basket is the preferred option. It will fund priority interventions of NHSSP at both central and service delivery levels. Expenditure items that qualify for funding from the basket will be clearly specified and approved by HSCC. Contributors to the pool will be GoSL through transfers of the appropriate vote(s) in the approved health budget(s), and those HDPs and global health initiatives, charities and foundations willing to join into such an arrangement. The NGOs and FBOs are not expected to join the pooling arrangement.
- III. *A Partnership Fund* - an off-budget account opened at the Bank of Sierra Leone by the Treasury Secretary on behalf of the partnership, for the purpose of meeting unbudgeted expenditures related to setting up and operating the partnership structures, including its secretariat (restructured and renamed Donor Coordination Office), special studies, emergencies, regular partnership meetings and summits, etc. Contributors will be the funding HDPs on a voluntary basis. The Partnership Fund will be under the control of HSCC with MoHS Permanent Secretary or Chief Medical Officer as one of the co-signatories and Chair or vice chair of HDP as the other co-signatory.
- IV. *Off-budget financing* for partners whose mandate does not allow them to co-mingle their funds. However all activities with corresponding budget have to be aligned with NHSSP and its MTEF and AOPs and captured in the Programme of Work.

7.4.3 Accounting and Financial Reporting

- I. *Financial* reports (quarterly, half-yearly, and yearly) will be produced using the Integrated Financial Management Information System (IFMIS) being implemented by the Government of Sierra Leone. The Local Governance Finance Department (LGFD) will ensure that all financial reports are copied to the Directorate of Financial Resources of MoHS.
- II. *In* close consultation with the Ministries responsible for Finance and for Local Government, MoHS will establish modalities for undertaking joint review of the quarterly district performance reports (PFM and progress towards the planned LC/AOP targets) as one of the conditions for further disbursement in accordance with Section 51 Sub-section (1) of the 2004 Local Government Act.

iii. *Public Expenditure Tracking Surveys (PETS)* will continue to be conducted annually; the areas of focus for each PETS will be jointly decided by the GoSL and all partners during annual reviews. Reports of PETS will be presented to the Health Review Summit.

7.4.4 Audit

- I The internal audit department will undertake internal audits to validate the financial management system on a day-to-day basis at central level. Similarly, the internal audit function is being extended by the MoFED to the local councils.
- I. The MoHS will ensure that external audits are conducted annually by the Auditor General's Department or by an auditor appointed by the Auditor General, in accordance with 2005 Government Auditing and Accountability Act.
- II. Implementing partners will be audited annually through an accepted mechanism.
- III. A Fiduciary Risk Assessment will be conducted annually and the findings presented to the Health Review Summit.
- IV. All such audits and review reports will be tabled before HSCC and made available to all Partners.

7.5 MONITORING, EVALUATION AND SUPERVISION

The NHSSP will primarily be monitored using its M&E Plan which includes routine data from the HMIS and periodic national surveys such as the National census, Demographic and Health Survey (DHS), Multi Indicator Cluster Survey (MICS), national impact assessments, service delivery perception surveys, etc.

Annex 2 1 sets out indicators which signatories to the Health Compact will hold each other to account in order to monitor the implementation of the Compact. At the end of each year, an independent entity will be contracted to assess the level of compliance of both Government and development partners with the Compact commitments, using the indicators in Annex 2.

The report of this assessment will be jointly reviewed by Government and its partners and recommendations made on how to improve in areas where progress is needed.

7.6 HUMAN RESOURCE FOR HEALTH

By the year 2015, the MoHS shall have in place adequate, well-managed, efficient and motivated human resources for health and social welfare capable of providing equitable access and distribution of services leading to a healthy and productive Sierra Leone through the following strategies:

- a) Provide and maintain a policy and strategic framework to guide Human Resources for Health (HRH) development and management.
- b) Strengthen institutional capacity for HRH policy, planning and management
- c) Upgrade and enhance competencies and performance of health workers
- d) Promote research into HRH interventions to provide evidence-based information for the improvement of service delivery
- e) Put in place strategies to enhance sustainability particularly staff salaries to ensure staff retention.

7.6.1 Technical Assistance

- I. The determination of needs for Technical Assistance (TA) will be demand-driven by the sector's needs, priorities and absorptive capacities, and will support institutional capacity strengthening. The needs should, as far as possible, be identified during the development of the AOPs, and will be set out in an Annual TA Procurement Plan.
- II. Use of national consultants will be given first priority where expertise is available, consistent with procurement regulations and guidelines. Terms of reference and selection of candidates will be reviewed and approved by all relevant partners.
- III. TA that falls outside of any formal technical cooperation arrangements with the GoSL/MoHS will be determined on a demand-driven basis according to the identified capacity gaps in the health sector and as endorsed by the HSCC. TOR will be developed by the MoHS, and posts will be advertised nationally, regionally and internationally.
- IV. Caution will be taken to ensure that any recruited long term technical assistance is not used merely as extra pairs of hands, but

will offer high level technical advice and build the capacity of relevant people and systems in the department of assignment. TOR for all long term technical assistance will clearly specify the technical assistant's counterpart and to which government officer the technical assistant will be directly accountable.

8. PREVENTION AND SETTLEMENT OF DISAGREEMENTS AND CONFLICT

- I. All health partners will work in a spirit of openness, transparency and mutual respect. Effective information flow and constructive dialogue are crucial for building and sustaining confidence and trust.
- II. In the event of disagreement or conflict, dialogue will be the first recourse for resolving the situation; this will be initiated immediately by the partners directly involved. Should a way out not result from this initial dialogue, the Chair of HSCC and the Coordinator of HDPs should be consulted and be involved in the resolution of the conflict. The issue under discussion will only be brought to the full HSCC should the first two steps fail to reconcile the disputing Partners.
- III. The Chair of HSCC and the Coordinators of HDPs and implementing partners respectively, will consult early over sensitive or potentially divisive situations in an effort to resolve the problem and avert avoidable conflict. The HSCC and the health summits offer opportunity to identify and address potential problems. This Compact will act as the guiding document for conflict prevention and resolution. Health partners will always seek to avoid unilateral action.
- IV. In the event of persistent disagreement, a DEPAC meeting will be arranged to discuss and resolve the conflict.
- V. In the case of persistent non-compliance with the provisions of this Compact, the health partners reserve the right to take corrective measures including suspension of the partner concerned or suspension of disbursements, as the case may be.
- VI. Non-compliance may include:
 - Substantial deviation from jointly determined policy, strategy, plan or budget without due consultation
 - Implementation of the programme stalls as a result of action or inaction by a partner or partners
 - Persistent failure of a partner to honour its obligations to the partnership within the agreed period
 - Concrete evidence of serious fraud or other mis-procurement, and/or lack of accountability
 - Persistent breach of the basic principles and provisions of this Compact.

9. AMENDMENT/TERMINATION

- I. Any modifications to the terms of this Compact may only be made through a written amendment between health partners who are signatories to the Compact under the leadership of GoSL. Such amendment will be signed by all health partners.
- II. Notwithstanding the provisions of article 9.1 above, the GoSL will discourage the inclusion of activities that are inconsistent with the sector program defined in the NHSSP.
- III. Withdrawal from this Compact may be effected by any signatory on giving 90 days notice in writing under the signature of the designated Head of the partner concerned. The 90-day period will permit a detailed analysis of the possible impact of the withdrawal on the plan of work, MTEF and AOP and/or resolution of the reason for the notice of withdrawal.

10. INCLUSION OF NEW PARTNERS

- I. Any new health partner wishing to cooperate with the MoHS should do so in accordance with the provisions of this Compact and upon signing it.
- II. Application for membership to this IHP+ country partnership will be made in writing and will be accompanied by a summary of the intending partner's programme(s). The letter of application will be addressed to the Minister of Health and Sanitation as Chairperson of the HSCC and the Coordinators of the Health Development & Implementing Partners.

11. DATE OF EFFECTIVENESS

- 11.1. This Compact will be deemed to have come into effect upon signing by the respective authorized representatives of the GoSL and at least two Health Development Partners and two Implementing Partners.
- 11.2. Unless otherwise amended in writing by the Health Partners who are signatories to the compact, the Compact will be effective for a period up to six months after the official ending of the Sierra Leone NHSSP i.e. 30 June 2016. The Compact will be reviewed, agreed upon and signed in the context of each subsequent Health Sector Strategic Plan.

12. ANNEXES AND DOCUMENTS

The contents of the following annexes and documents are an integral part of the Compact:

Signatories

For and behalf of:



Mrs Zainab Hawa Bangura
Minister of Health and Sanitation
GOVERNMENT OF SIERRA LEONE



f Dr Samura Kamara
Minister of Finance and Economic Development
GOVERNMENT OF SIERRA LEONE



Amb. Dauda Kamara
Minister of Local Government and Rural Development
GOVERNMENT OF SIERRA LEONE





PHIL FRECKLETON ACTING HEAD FOR:

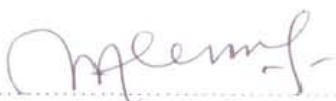
Mr. Phil Evans
Head of Office Sierra Leone
UK Department for International Development





Mr. Jean-Pierre Reymondet-Commy
Country Representative *Head of Delegation*
European Union



Ms. Sinead Walsh
Chargé d'Affaires,
Embassy of Ireland


Mr. Mahimbo Mdoe
Country Representative
United Nations Children's Fund (UNICEF)



Dr. Wondimagegnehu Alemu,
Country Representative,
World Health Organisation (WHO)


Mrs. Ratidzai Ndhlovu,
Country Representative
United Nations Population Fund (UNFPA)



Mulunesh Tennagashaw
Joint United Nations Program on HIV/AIDS
Country Coordinator



Vijay Pillai
Country Manager
The World Bank


.....
Dr Samuel Onwona
Resident Representative
African Development Bank (ADB) 2
Dec. 15, 2011

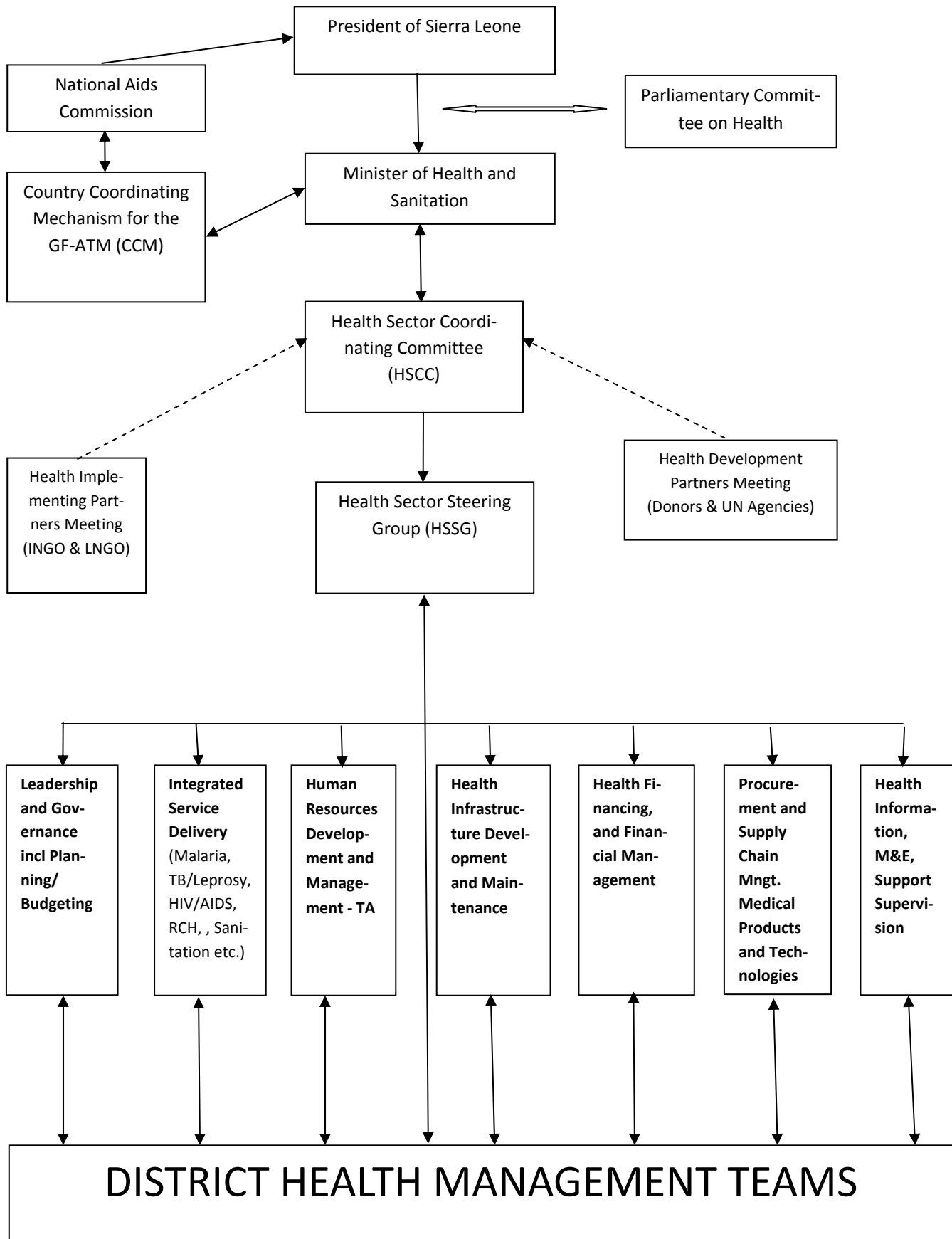

.....
Mr Abdul Kareem Jalloh
Director
Medical Research Center – For NGOs Dec. 19, 2011


.....
Mr Walter Carew
Executive Director
Christian Health Association of Sierra Leone—For FBOs


.....
Mr Charles Mambu
Director
Health for all Coalition – For Civil Society Organisations


.....
Mr Grant Maclean
Director of International Programs
Africa Mercy
Mercy Ships

Annex 1: Coordination Mechanism



Annex 2: IHP+ Development Partners standard performance measures

| Expected Results | Indicator No. | Standard Performance Measure | Target for 2015 |
|--|---------------|---|--|
| 1. Commitments documented and mutually agreed | 1DP, 1G | Proportion of all partners who sign up to the Sierra Leone Country Health COMPACT | At least 90% of all Partners have signed up to the Country Health COMPACT |
| 2. Support is based on country plans & strategies, including to strengthen Health Systems | 2DPa | Percent of aid flows to the health sector that is reported in national health sector budgets. (PD3) | Reduce by 60% the proportion of aid flows to the health sector not reported on government's budget(s) (with at least 85% reported on budget). |
| | 2DPb | Percent of current capacity-development support provided through coordinated programmes consistent with national health sector strategic plan (PD4) | 50% or more of capacity development support to the health sector are based on national health sector strategic plan |
| | 2DPc | Percent of health sector aid provided as programme based approaches. (PD9) | 66% of health sector aid flows are provided in the context of programme based approaches |
| 3. Funding commitments are increased &/or longer-term | 3DP | Percent of health sector aid provided through multi-year commitments | 90% (or an equivalent published target) of health sector funding provided through multi-year commitments (min. 3 years) |
| 4. Funds are disbursed predictably, as committed | 4DP | Percent of health sector aid disbursements released according to agreed schedules in annual or multi-year frameworks (PD7) | 66 % of health sector aid disbursed within the fiscal year for which it was scheduled |
| 5. Country Systems for procurement & public financial management are used and strengthened | 5DPa | Percent of health sector aid that uses the national procurement system. (PD5b) | Score 5+: 66 % of health sector aid for procurement to the public sector using the national public procurement system |
| | 5DPb | Percent of health sector aid that uses public financial management systems. (PD5a) | Score 3.5-4.5: 50 % of health sector aid to the public sector using the national PFM systems |
| | 5DPc | Number of parallel Project Implementation Units (PIUs) (PD6) | Reduce by two-thirds the stock of parallel project implementation units (PIUs) |
| 6. Resources are being managed for Development Results | 6DP | existence of agreed transparent and monitorable performance assessment framework to assess progress in the health sector (PD11) | Single national performance assessment framework is used as the primary basis to assess progress in the health sector |
| 7. Mutual Accountability is being demonstrated | 7DP | existence of a system for mutual assessments of progress made in implementing commitments in the health sector, including on aid effectiveness* (PD12) | Annual mutual assessment of progress in implementing health sector commitments & agreements (such as the IHP+ country COMPACT and on aid effectiveness in the health sector) |
| 8. Civil Society actively engaged | 8DP | Evidence of support for Civil Society to be actively represented in health sector policy processes - including Health Sector planning, coordination & review mechanisms | All Signatories can provide some evidence of supporting active Civil Society engagement. |
| Level of compliance of Implementing partners with the COMPACT commitments | 9 | Degree to which IMP comply with alignment and harmonization elements of the COMPACT | Civil Society constituencies operate within their respective umbrella organizations; and harmonise with other IMPs |
| Implementing partners' participate in central and local Council planning and coordination mechanisms | | Degree to which IMPs coordinate their support, activities with MOHS or the DHMTs | Proportion of IMPs who operate through the LC health plans |
| Implementing partners report through HMIS at LC and central levels as appr. | | Proportion of IMPs who use the common monitoring framework and report through the national HMIS | Proportion of IMPs that report through the national HMIS |

Annex 3: IHP+ GoSL Standard Performance Measures

| EXPECTED OUTPUT | INDICATOR # | INDICATOR | TARGET |
|--|-------------|--|--|
| 1. Commitments are documented and mutually agreed | (IG) | IHP+ COMPACT or equivalent mutual agreement in place | COMPACT or MOU signed by at least 90% of eligible partners |
| 2. Support is based on country plans & strategies, including to strengthen Health Systems | (Ga) | National Health Sector Plans/Strategy in place with current targets & budgets that are being jointly assessed | NHSSP with current targets and budgets is being jointly implemented and jointly monitored |
| 3. HRH Policy and Plan in place and being implemented | (2Gb) | Costed and evidence-based HRH plan in place that is integrated with the national health plan | A costed, comprehensive national HRH plan (integrated with the health plan) is being implemented |
| 4. Funding commitments are increased &/or longer-term | (3G) | Proportion of public funding allocated to Health. | Per capita public allocation to health rising above inflation rate annually |
| 5 a Per capita health allocation to health consistent with global estimates | 3a | Total per capita allocation to health increased progressively to level of global estimates | Per capita allocation at US\$ 19 by 2011 and US\$ 29 by 2014 |
| 6. Funds are disbursed predictably, as committed | (4G) | Proportion of health sector funding disbursed against the approved annual budget | 50 % of health sector funding disbursed against the approved annual budget; Halve the proportion of health sector funding not disbursed against the approved annual budget |
| 7. Country Systems for procurement & public financial management are used and strengthened | (5G) | Country procurement and public financial management systems for the health sector have a reform programme in place to achieve these | Improvement of at least one measure on the four-point scale used to assess performance for this sector |
| 8. Resources are being managed for Development Results | (6G) | An agreed transparent and monitorable performance assessment framework is being used to assess progress in the health sector | A transparent and monitorable performance assessment framework is in place to assess progress in the health sector. |
| 9. Mutual Accountability is being demonstrated | (7G) | Mutual Assessments, such as Joint Annual Health Sector Reviews, have been made of progress implementing commitments in the health sector, including on aid effectiveness | Mutual assessments (such as a joint Annual Health Sector Review) are being made of progress implementing commitments in the country health compact |
| 10. Government Leadership is being demonstrated effectively | 8 | Partner assessment of GoSL (MOHS) performance in its leadership role | Score of 3 or above on a 1 to 5 assessment/perception scale |
| 11. Policy, plan and budget development processes transparent and inclusive | 9 | Are the policy, plan and budget development processes transparent and inclusive? | Score of 4 or above on a 1 to 5 assessment/perception scale |
| 12. Partnership structures and processes functioning effectively and as scheduled | 10 | Are the Partnership structures and processes functioning effectively and as jointly scheduled | Score of 4 or above on a 1 to 5 scale |
| 13. Level of GoSL and HDP collaborating with Civil Society | 11 | Are GoSL and HDPs collaborating with and supporting Civil Society partners | Implementing Partners fully on board and participating equally. |
| 14. Scheduled Reports timely | 12 | Are scheduled reports timely? | 90 % of scheduled reports received on time. |