ReBUILD FOR RESILIENCE

IMPLEMENTATION OF THE REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, & ADOLESCENT HEALTH POLICY IN SIERRA LEONE

Mother and baby at Makeni Regional Hospital, Sierra Leone. H6 Partners & Abbie Trayler-Smith via Flickr

Background

- Since 2008, Sierra Leone has made reproductive, maternal, newborn, child and adolescent health (RMNCAH) a national priority via healthcare reforms.
- The launch of the Free Health Care Initiative (FHCI) in 2010 also increased access to quality healthcare for pregnant and lactating women, and children under five years.
- However, progress in improving maternal and child mortality remains low and Sierra Leone has one of the world's highest maternal mortality rates.
- Implementation research and the use of an ethnographic approach to policy analyses remain limited in the global south. Focus has been on system-level factors that challenge policy implementation. There's been less attention on the interactions, dynamics, opportunities, and challenges faced at national and sub-national levels to translate policy objectives into actions.

This study sought to understand the constraints and opportunities in the implementation of RMNCAH policy at the national and sub-national levels in Sierra Leone.

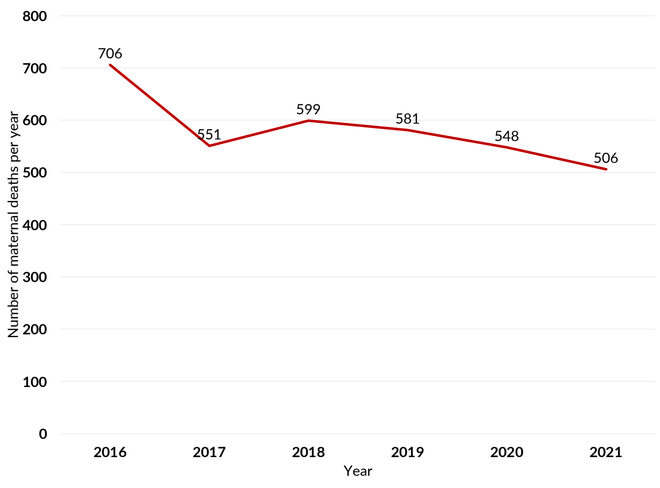
What we did

- Qualitative research using a multisite ethnographic methodology
- The first author was embedded in and directly observed policy implementation within the Reproductive and Child Health Directorate of the Ministry of Health and Sanitation (MoHS) in Freetown
- Also embedded in two District Health Management Teams (DHMTs)
- 30 in-depth interviews with MoHS staff, civil society and local councils
- Three power mapping exercises with health workers directly involved in sub-national RMNCAH policy implementation

What we found

Maternal deaths in Sierra Leone 2016-2021

Data from MDSR Report



Motivating factors for policy implementers

- Implementers have diverse and deeply rooted motives and interests.
- The desire to foster a healthy population emerged as the main motivator for policy implementers at both national and sub-national levels who described working in very complex environments:

"Well, one of my greatest motivations is, I am a parent who has a girl child growing up and we know the circumstances surrounding the girl child or adolescents in general. The risk associated to them at that age with regards to health in particular is too much. They are exposed to teenage pregnancy, HIV and other STIs and the levels are going up. So, I thought it fit in my own way to contribute positively to influence this campaign."
(National-level interview)

Implementation complexities

- **Complex institutional arrangements** at the MoHS negatively impact the implementation. For example, DHMTs are decentralized and devolved to local councils, however, service level agreements between NGOs and the MoHS are signed at the central level without the involvement of councils, programs or DHMTs. As such, it becomes difficult to regulate the operations of the NGOs during implementation, creating room for **poor coordination and duplication of activities** in the frontline.
- DHMT members said that the **uncoordinated construction of health facilities** by politicians 'to win votes' also affected the implementation of services in the frontline. This pushed DHMTs to allocate limited resources to the new facilities to satisfy political figures and their followers.

Resource availability

- Implementation of the RMNCAH policy is constrained by a lack of resources including essential drugs, equipment and skilled personnel, plus dysfunctional referral systems and late disbursement of funds by the government.

"Well, we are supposed to get antibiotic injects here because this is a CHC [Community Health Center]. If someone comes with severe pneumonia I should administer first aid treatment but it is not available. So, I will just make a small note and refer."
(District-level interview)

- **Untimely disbursement of funds from the government,** coupled with local-level bureaucracy, held up implementation of activities at various levels. For example, DHMTs reported getting funding for the first two quarters of 2022 in August 2022. The absence of District Medical Officer to authorise payments was also described as a contributing factor. As the result, implementers seek funding from NGOs working in the districts, who only provide support to implement activities that "falls within their project line at that time." (District-level interview)
- **Utilisation of available resources** was a major issue undermining service delivery at both levels. DHMT staff, for example, reported not receiving fuel support from DHMT management, impacting on their ability to conduct monthly mentoring, coaching and supervisory visits with staff at peripheral health units. Similar frustrations were heard from the national-level staff.
- Frontliners **use their own resources to accomplish their tasks** and maintain trust, e.g. buy essential goods and drugs for patients - sometimes they are paid back later and sometimes not.

Despite these challenges, frontline workers saw positives in their roles including:

- Capacity building
- Good working relationships
- Appreciation from communities
- Promotion
- Reduction in vaccine-preventable disease
- Reductions in maternal and child mortalities and morbidities

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Conclusion

RMNCAH policy implementation in Sierra Leone is constrained by complex issues that reach beyond limited resources and dysfunctional systems. Power dynamics within the DHMTs, individual interests, and resource management undermine implementation of frontline activities. The implementation of RMNCAH policy remains challenged by numerous complex issues that call for increased national ownership, involvement of DHMTs in national-level decision making and consultations at the various levels, including in the communities, to sustain the gains in health outcomes.

Further information on this study and outputs

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