Sierra Leone

Quality, Equity, Dignity

A Network for Improving Quality of Care for Maternal, Newborn and Child Health

Country context

POPULATION & MORTALITY RATES	2017	2020	2022
Population (in million)[1]	7.6	8.2	8.4
Maternal Mortality Ratio per 100,000 live births[2]	1120	443	–
Neonatal Mortality Rate per 1,000 live births[3]	34	32	31
Stillbirth Rate per 1,000 births[3]	24	23	23

NATIONAL COVERAGE OF KEY INTERVENTIONS (2019)	%
Antenatal care (4 or more visits)[4]	79
Skilled birth attendance during delivery[5]	87
Institutional deliveries[6]	83
Post natal visit for baby (within 2 days of birth, medically trained provider)[6]	83
Postnatal care for mother (within 2 days of birth, medically trained provider)[6]	86
Caesarean section rate[7]	
Family planning[8]	48
Initial breastfeeding (1 hour of birth)[9]	75
Exclusive breastfeeding rate (of infants under age of 6 months)[10]	54

1. United Nations, Department of Economic and Social Affairs, Population Division (2022). World Population Prospects 2022, Online Edition. https://population.un.org/wpp/Download/Standard/MostUsed/
2. World Health Organization. (2019). Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division: executive summary. World Health Organization. https://apps.who.int/iris/handle/10665/327596
   World Health Organization (2023). Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. https://apps.who.int/iris/handle/10665/366225
3. United Nations Inter-agency Group for Child Mortality Estimation (2023). https://childmortality.org/
4. WHO/SHR Global Database, Percentage of women aged 15–49 years attended at least four times during pregnancy by any provider, September 2022.
5. UNICEF/WHO joint database on SDG 3.1.2 Skilled Attendance at Birth. May 2022.
6. United Nations Children's Fund, Division of Data, Analysis, Planning and Monitoring (2022). Global UNICEF Global Databases: Maternal and Newborn Health Coverage Database, New York, May 2022.
7. WHO Global Health Observatory https://www.who.int/data/gho
8. United Nations, Department of Economic and Social Affairs, Population Division (2020). Estimates and Projections of Family Planning Indicators 2020. New York: United Nations.
9. United Nations Children's Fund, Division of Data, Analysis, Planning and Monitoring (2022). Global UNICEF Global Databases: Infant and Young Child Feeding: Ever breastfed, Early initiation of breastfeeding, Exclusively breastfed for the first two days after birth, New York, October 2022.
10. United Nations Children's Fund, Division of Data, Analysis, Planning and Monitoring (2022). Global UNICEF Global Databases: Infant and Young Child Feeding: Exclusive breastfeeding, New York, October 2022.

Milestone progress (2017-2022)

STRATEGIC OBJECTIVES	MILESTONE DELIVERABLES	2017	2020	2022
LEADERSHIP	Supportive governance policy and structures developed or established	○	●	●
	Quality of care for maternal and newborn health roadmap developed and being implemented	○	●	●
ACTION	On-site coaching visits occuring in learning districts	○	●	●
	Quality improvement coaches trained	○	●	●
	QoC coaching manuals developed	○	●	●
	Learning districts and facilities selected and agreed upon	○	●	●
	QoC implementation package developed	○	◐	●
	Adaptation of MNH QoC Standards	○	●	●
	Orientation of learning districts and facilities	○	●	●
LEARNING AND ACCOUNTABILITY	Mechanism for community participation integrated into QoC planning in learning districts	○	●	◐
	A research institution to facilitate documentation of lessons learned identified and is active	○	●	●
	District learning network established and functional (reports of visits)	○	◐	●
	Common indicator data collected, used in district learning meetings, and reported upwards	○	●	●
	Baseline data for MNH QoC common indicators collected	○	●	●
	Common set of MNH QoC indicators agreed upon for reporting from the learning districts	○	●	●

Key: ● *On track (achieved)* ◐ *In progress (initiated but not completed)* ● *Not started* ○ *No information*

Ensuring MNH QoC core indicators are available in routine HMIS

DATA ELEMENTS	Integrated into HMIS	Collected	Reported	Used	Source
Pre-discharge maternal deaths	●	●	●	●	
Maternal deaths by cause	●	●	●	●	
Neonatal deaths by cause	●	●	●	●	Collected by hospital special care baby units
Facility stillbirth rate (disaggregated by fresh/ macerated when possible)	●	●	●	●	
Pre-discharge neonatal mortality rate	●	●	●	●	
Obstetric case fatality rate (disaggregated by direct/indirect when possible)	●	●	●	●	
Pre-discharge counselling for mother and baby (woman-reported)	●	●	●	●	Experience of care surveys
Companion of Choice (woman-reported)	●	●	●	●	Experience of care surveys
Women who experienced physical or verbal abuse in labor or delivery (woman-reported)	●	●	●	●	Experience of care surveys
Breastfeeding within one hour	●	●	●	●	
Immediate postpartum prophylactic uterotonic for PPH prevention	●	●	●	●	
Birthweight documented	●	●	●	●	
Premature babies initiating KMC	●	●	●	●	
Basic Hygiene Provision	●	●	●	●	WASH assessments
Basic sanitation available to women and families	●	●	●	●	

Key: ● *YES* ● *NO* ○ *No information*

Creating an enabling environment for sustainability and scaling up of MNH QoC

Leadership

The QoC agenda has advanced led by the Department for Reproductive and Child Health (RCD) developing MNH QoC Standards as the entry point for quality across the health sector (*2016*). The Standards informed the *National Quality and Patient Safety Policy and Roadmap* (*2017- 2021*) and an updated Policy and Roadmap was launched in 2021 (36), and the implementation strategy the '*Quality RMNCAH Strategic Roadmap'* (*2020-2024*) (37).

- **At national level, a National Quality Management Program has been established** with a Manager, Technical Officer seconded by WHO, QoC Officers for MNCAH and a Patient Safety Officer. The National QoC Steering Committee is chaired by the Chief Medical Officer and the Director of Reproductive and Child Health (RCH) as the secretary. Implementation is led by the National Technical Working Group with the Director RCH serving as the Chairman and Manager QoC as the secretary.
- **Subnational roles and responsibilities are clearly defined at district and facility level;** QoC is integrated into all District Health Plans, operationalized through a QoC management structure comprised of a new cadre of thirty-six district and hospital QoC and Patient Safety Officers (Quality Officers).
  - Quality Officers have a defined budget-line in the Ministry, and the Terms of Reference establish the responsibility to lead QoC at district and facility levels by guiding QI staff in programme units in districts and clinical wards in facilities.
  - Quality Officers convene quarterly to share learning and discuss challenges and solutions. Issues are addressed to a National Quality Programme Manager to resolve or take forward with the National Quality TWG comprising programme managers and development partners.
  - This is considered a stepping-stone to ensure governance and accountability structures are put in place to ensure sustainability of the QoC initiative and inform scale up.

Scaling up pediatric quality of care through nurse led care and pediatric death autits

Improving access and quality of child health services is a priority and while progress has been made in reducing child mortality, Sierra Leone still has a high burden of child deaths that can be prevented. In 2021, the U5MR was 105 deaths per 1000 live births (UNICEF, 2023). As part of the country's effort to reduce child mortality following the Ebola outbreak in 2014-2016, the Ministry of Health and Sanitation (MoHS) identified district hospitals, which serve as the first level hospital referral centres, as targets for implementing comprehensive quality of care programme for child health by the MoHS. Two interventions have been successfully rolled out in district hospitals – ETAT and introduction of paediatric death audits.

In 2016, Sierra Leone had 3 doctors per 100,000, and only three specialist paediatricians and bed occupancy was often above 100%. Despite this, in district hospitals, emergency care management was often provided only by doctors.

- Starting in 2016, the MoHS rolled out an ETAT course to improve the clinical knowledge and skills of nurses providing care in accident and emergency and paediatric wards in hospitals. The aim was an improvement of clinical outcomes through task-shifting emergency care of children from doctors to nurses. A combination of hospital assessments, on-the-job training, clinical mentoring, provision of simple point of care diagnostics, and changes in layout and flow of patients was implemented over a 6-month period. Following the successful pilot of the intervention in the regional hospital, the implementation package was subsequently rolled out across the district hospitals in the country. Short term outcomes include a reduction of pediatric mortality, and improvement in clinical care process indicators. However, the longer-term outcomes of these were: foundation of the successful roll out and establishment of a national quality of care programme in maternal, newborn and child health and task shifting of emergency paediatric care in trained nurses in hospitals.
- Building on this success, in 2019, a child death audit and review system was introduced initially in district hospitals and then scaled up to CHCs. The aim is to roll-out child death audit process as an additional quality improvement tool to identify modifiable factors of facility-based child deaths and actions to address and prevent these deaths.

Building learning health systems for quality MNCH

A key strategic objective of the national QOC roadmap is to document and share learning within and between health facilities. These learning forums are geared towards providing a platform for sharing experience in adapting and implementing QoC initiatives towards achieving the SDG MNCH goals. National and districts learning forums have been organised in 2021 and 2022.

National level

Sierra Leone is hosting annual learning collaborative sessions to showcase progress and lessons learned from quality of care for MNCH implementation at national, district and facility level.

The Second National Healthcare Quality and Safety Summit was hosted at the Freetown International Conference Center with a theme

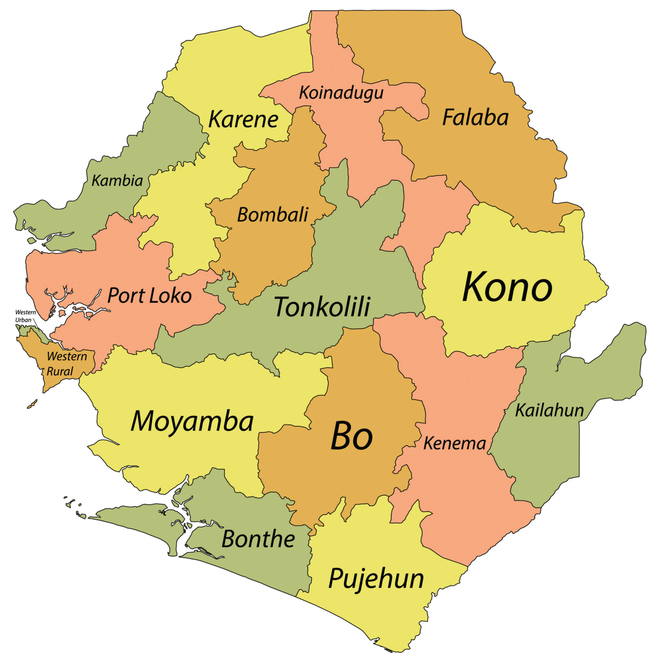
"Quality Conscience: Doing the Right Thing"
"Quality: My Priority, Your Priority, Our Priority"
"Celebrating Successes and Learning from our Journey"

The summit demonstrated that Sierra Leone can achieve breakthrough improvements at point of care through consistent use of the QI methodology/approach for problem solving. The sessions of the summit provided a venue for in-depth reflections and meaningful contributions to address the persistent gaps in quality-of-care improvement.

- *Improving living conditions of health workers for equity*
- *Robust supply chain management*
- *Continuous capacity building on QI*
- *Strengthening of the regulatory capacity in the country*
- *Improving coordination at levels*
- *Addressing structural challenges such as referrals, infrastructure, WATSAN*
- *Improving surgical healthcare and safety*
- *Improving QoC measurement and data management*
- *Democratization of QI initiatives in the country*

At district and facility level, learning sessions in the four districts of Pujehun, Kailahun, Western Area Urban and Rural, peer-to-peer learning activities are established across hospitals, and virtual learning and updating sessions are held with QoC Officers.

Map of the districts and learning facilities



There are 2 quality of care officers assigned for each district in Sierra Leone

Taking forward the unfinished and emerging agenda for quality MNCH

A number of key challenges exist to the scale up of quality care

- Weak regulatory system.
- Breakdown in supply chain of essential and lifesaving commodities.
- Limited finance from government to support operation in facilities, districts, and QOC management.
- Data use culture still limited.
- Attrition of health workers at the leadership level affecting QI project implementation.

The top priorities for the phase of work are:

- Scaling up the implementation of QoC beyond MNH to cover other programmatical areas (HIV).
- Strengthen the Regulatory System.
- Initiate Community Engagement Program to districts.
- Patient safety situational analysis for RMNCAH.
- Patient charter developed and disseminated.
- Experience of Care (EoC) assessments.

© UNICEF/UNI150924/Asselin

© UNICEF/UN0581333/Tremeau

© UNICEF/UN0464631/Dejongh