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Health
Budget Brief

SIERRA LEONE
AUGUST 2026

Key messages and recommendations

1 Health receives only 4.6 per cent of the national budget[1] – less than a third of the Abuja Declaration target of 15 per cent – as allocations decreased by 7 per cent to SLE1.38 billion in 2026. This level of underinvestment constrains Sierra Leone's human capital development by limiting progress in child survival, nutrition, learning readiness, productivity and long-term economic growth. Without a sustained increase in real health spending, the country risks falling short of its 2030 Universal Health Coverage (UHC) commitments.

Recommendation: The Ministry of Finance, in collaboration with the Ministry of Health, should set a clear medium-term financing pathway beginning in the 2027 budget, with annual increases in the health budget that at least keep pace with overall expenditure growth and inflation. This pathway should progressively move health allocations toward the Abuja target of 15 per cent of public expenditure and ensure that primary health care (PHC) receives a protected and increasing share, consistent with the National Health Sector Strategic Plan target of at least 12 per cent.

2 Inefficiencies in health spending limit impact and value for money. Health spending efficiency remains below the Economic Community of West African States (ECOWAS) average, suggesting that Sierra Leone generates fewer health outcomes for each Leone invested. Unless these inefficiencies are addressed, additional resources may not translate into stronger service delivery or better outcomes, weakening the return on public investment.

Recommendation: The Ministry of Health, with support from the Ministry of Finance, should prioritize efficiency reforms – including a better balance between staffing and service delivery inputs, increased capital investment, stronger district-level financial management, and wider use of performance-based financing where appropriate – to ensure that each additional Leone invested delivers measurable gains in access, quality and health outcomes.

3 Local Councils receive only around 4 per cent of the domestic health budget, constraining equitable PHC delivery. Transfers are often delayed, unpredictable and insufficient, weakening local planning and front-line service delivery, especially in rural and underserved areas. If not addressed, these financing bottlenecks risk widening regional disparities, increasing out-of-pocket costs for vulnerable households, and weakening the delivery of decentralized health services.

Recommendations

- The Ministry of Finance should increase and ring-fence transfers to Local Councils and ensure timely, predictable quarterly releases, with priority given to primary health-care functions.
- The Ministry of Health should strengthen the use of disaggregated expenditure and service delivery data to identify, monitor and address inequities across districts, particularly in child health spending.
- Efforts to strengthen Local Councils' own-source revenue should address administrative bottlenecks, overlapping collection mandates between Local Councils and chiefdom authorities, weak coordination, and gaps in political and administrative leadership, while fully implementing recent revenue mobilization reforms.

1. The analysis uses total government expenditure and net lending, including interest payments on public debt, as the denominator to ensure comparability across sectors and reflect the extent to which debt servicing constrains fiscal space for health. Consequently, the expenditure shares presented in this Brief may differ from those reported by the Government of Sierra Leone, which typically calculates sectoral allocations using primary expenditure (excluding interest payments). By incorporating debt servicing, the analysis provides a more comprehensive and realistic assessment of the resources available to the health sector, recognizing that debt obligations compete directly with health and other social sectors for limited public funds.

4 **With 75 per cent of the health budget allocated to salaries and only 4 per cent to capital investment in 2026, critical gaps in infrastructure, equipment, medicines and supplies persist – especially at PHC level.** At the same time, Sierra Leone faces a severe shortage of skilled health workers, with only 11.2 skilled health workers per 10,000 people, compared to the World Health Organization (WHO) benchmark of 44.5 required to support progress towards UHC. Without a more balanced spending mix, higher allocations may continue to finance inputs without sufficiently improving service availability, quality or outcomes.

Recommendations

- The Ministries of Finance and Health should progressively rebalance spending towards goods, services and capital investment, with sustained funding for PHC infrastructure, equipment, essential medicines and medical supplies, and systems-strengthening.
- The Ministry of Health should scale up the recruitment, training, deployment and retention of skilled health workers – particularly physicians, midwives and other critical cadres – to progressively close workforce gaps and improve service delivery quality.

5 **Heavy reliance on external and out-of-pocket financing threatens the sustainability and equity of health financing.** Government health spending accounts for less than 20 per cent of total health expenditure, out-of-pocket payments remain high, and nearly 90 per cent of donor funding is off-budget. Without stronger domestic and pooled financing, the sector faces heightened risks of funding volatility, weak accountability, service disruption and financial hardship for vulnerable households.

Recommendations

- The Ministry of Finance should prioritize domestic resource mobilization for health, including well-designed innovative financing mechanisms, to reduce dependence on external funding and improve financing predictability.
- The Ministry of Health should use the ongoing review and update of the Health Financing Strategy to identify, assess and implement sustainable domestic funding options for PHC and accelerate progress towards UHC.
- Priority options include establishing a basic health insurance fund; strengthening risk pooling through national social health insurance or community-based health insurance schemes; earmarking selected tax revenues for health, such as a free health care withholding tax, sin taxes, mining sector revenues, transaction taxes and vehicle licence fees; and exploring performance-based financing and Direct Facility Financing.

6 **Budget execution challenges weaken budget credibility and allocative efficiency.** Although overall health budget execution has averaged around 100 per cent in recent years, large variations across spending agencies and administrative units point to persistent misalignment between planned and actual spending. This weakens budget credibility, reduces the effectiveness of prioritization and risks diverting resources away from high-impact services.

Recommendations

- The Ministry of Finance should strengthen commitment controls, fiscal discipline, cash-flow planning, and the capacity of budget officials in planning, monitoring and results-based budgeting.
- Stronger oversight and enforcement – supported by high-level political commitment – are essential to ensure that budget execution aligns with approved priorities and translates into improved service delivery and health outcomes.

Introduction

This Budget Brief examines Sierra Leone's health expenditure in the context of the 2026 national budget. It assesses the adequacy, equity, efficiency, credibility and sustainability of public spending on health between 2020 and 2026, with particular attention to implications for children, PHC and progress towards UHC. The Brief is intended to inform the Government, development partners, civil society organizations and other stakeholders, and to support efforts to improve the efficiency, sustainability and impact of health financing.

Methodology

For this Budget Brief, health sector expenditure is defined as allocations to the Ministry of Health, transfers to Local Councils, and allocations to national health sector regulatory bodies, statutory agencies and professional councils, as shown in Table 1. The analysis draws primarily on Budget Speech Annexes and focuses on original budget allocations, excluding supplementary budgets. Where the annexes are incomplete – particularly for salaries and capital expenditure – the brief supplements these data with Annual Public Accounts and information provided by the Ministry of Finance. The analysis focuses mainly on domestically financed, on-budget health expenditure, while the financing section also presents externally financed on- and off-budget expenditure. Differences across Budget Speech Annexes, Annual Public Accounts, and Development Assistance Data point to the need for stronger data reconciliation and greater transparency in health financing reporting. Inflation adjustments use the GDP deflator from Budget Speech Annex 1, with 2020 as the base year; exchange rates are drawn from Budget Speech Annex 2. Total government expenditure is calculated as the sum of wages and salaries, non-salary non-interest recurrent expenditure, domestic capital expenditure, foreign loans and grants, capital transfers and interest payments.

TABLE 1

Health ministries, departments and agencies analysed in this Budget Brief

Ministry, department or agency								
Ministry of Health								
National health sector regulatory bodies, statutory agencies and professional councils:								
National Medical Supplies Agency	Dental and Medical Board	Health and Service Commission	National HIV and AIDS Commission	Teaching Hospitals Complex Administration	Post Graduate College of Health Specialists	National Public Health Agency	Pharmacy Board Services	Allied Health Professions Council
Local Councils								

Overview of the health sector in Sierra Leone

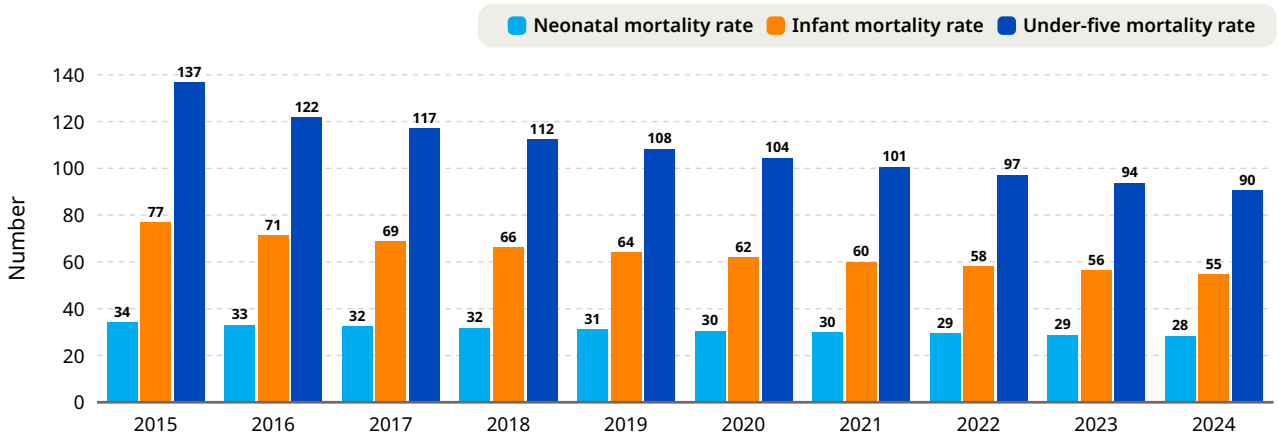
KEY HEALTH INDICATORS

The number of deaths of children decreased from just over 41,000 in 2015 to just over 31,000 in 2023, but mortality remains high. Children under five continue to account for the largest share of these deaths, estimated at just under 24,000 in 2023. At the current pace of improvement, Sierra Leone remains off track to achieve the 2030 Sustainable Development Goal targets for under-five, neonatal and maternal mortality.

The under-five mortality rate fell from 137 deaths per 1,000 live births in 2015 to 90 in 2024 (*see Figure 1*). Although this is slightly below the West and Central Africa average of 91, it remains well above the sub-Saharan Africa average of 71, underscoring the need for faster progress in child survival.

FIGURE 1

Neonatal, infant and under-five mortality rate, 2015–2024



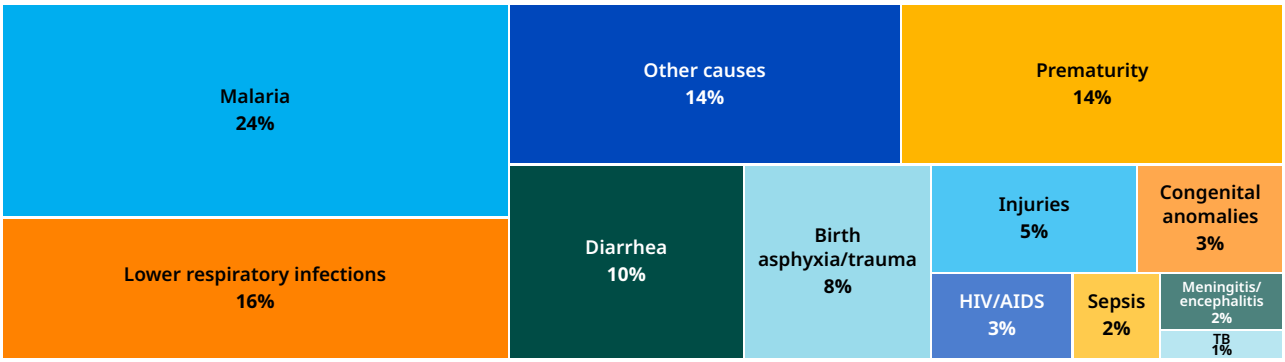
Source: UN Inter-agency Group for Child Mortality Estimation, <https://childmortality.org/>.
Note: Mortality rate is calculated as the number of deaths per 1,000 live births.

Malaria remained the leading cause of death among children under five in 2021, accounting for about a quarter of under-five deaths. Other major causes included lower respiratory infections, birth asphyxia and trauma, prematurity and diarrhoea (*see Figure 2*), highlighting the continued importance of prevention, timely treatment and stronger PHC.

The number of health workers increased by more than 50 per cent between 2020 and 2026, from 12,515 to 19,619. Health worker density also improved, rising from 15.8 to 21.8 health workers per 10,000 population (*see Figure 3*). While this represents considerable progress, staffing levels remain insufficient relative to population needs and UHC requirements.

FIGURE 2

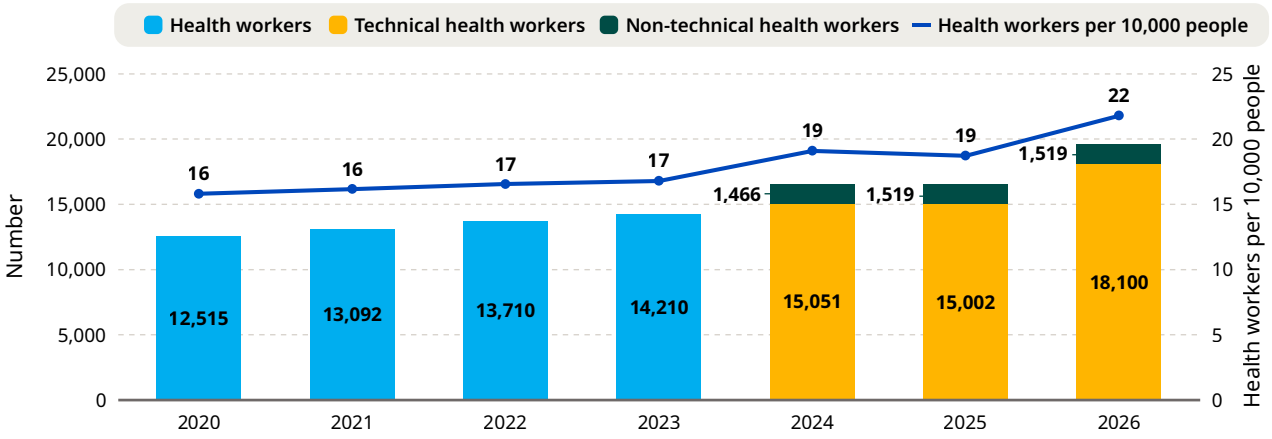
Percentage of under-five deaths by cause, 2021



Source: UN Inter-agency Group for Child Mortality Estimation, <https://childmortality.org/>.

FIGURE 3

Size of the health workforce on the government payroll



Source: Authors' calculations based on data from FY2020–2026 Budget Speech Annexes and total population from UN World Population Prospects.
Note: The split between technical and non-technical health workers is only available for 2024–2026.

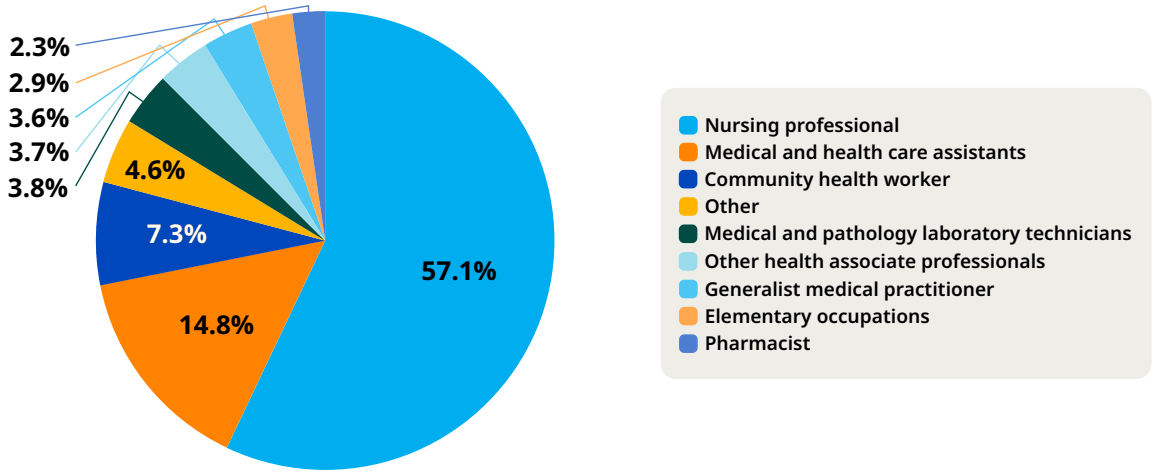
Ministry of Health data for 2025 show a highly nurse-centred workforce structure (*see Figure 4*). Nursing professionals account for 57 per cent of all health workers, followed by medical and health-care assistants (15 per cent) and community health workers (7 per cent). Generalist medical practitioners represent only 4 per cent, while pharmacists account for 2 per cent. This skills mix reflects reliance on mid-level and support cadres and points to potential constraints in access to advanced and specialized care.

Sierra Leone continues to face a substantial shortage of skilled health workers. In 2025, the country had 9,872 physicians, midwives and nurses – equivalent to 11.2 per 10,000 population. This is far below the WHO benchmark of 44.5 skilled health workers per 10,000 population needed to support UHC and the Sustainable Development Goals.

STRATEGIC AND INSTITUTIONAL FRAMEWORK FOR THE HEALTH SECTOR

FIGURE 4

Composition of the health workforce by occupation, 2025



Source: Authors' calculations based on data obtained from the Ministry of Health.
Note: The data reflect monthly salaries only and do not include allowances or other benefits. Occupation groups are based on the WHO's international classification of health workers (World Health Organization, 'Classifying health workers: Mapping occupations to the International Standard Classification', WHO, Geneva, 2019, <https://cdn.who.int/media/docs/default-source/health-workforce/dek/classifying-health-workers.pdf>.

Sierra Leone's health sector is guided by a mix of updated laws, older legislation and national policy frameworks that define roles, responsibilities and service delivery priorities (*see Figure 5*):

- The **Public Health Act (2022)** serves as the cornerstone of public health governance. It consolidates provisions on disease prevention and control, surveillance, sanitation, and emergency preparedness and response.
- The **Local Government Act (2004)** defines decentralization across different levels of care: primary and secondary care fall under the jurisdiction of Local Councils, while tertiary hospitals remain under the jurisdiction of the Ministry of Health at central level.
- The **Free Healthcare Initiative,** launched in 2010, guarantees free access to essential health services for pregnant women, lactating mothers, and children under five years of age.
- Several additional policies and strategic frameworks guide sector planning and implementation, including the National Health and Sanitation Policy, the National Health Sector Strategic Plan, the Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy (2017–2021), the Child Survival Action Plan (2023–2025) and the Essential Health Service Package. Effective implementation of these instruments is central to achieving the 2030 UHC target and ensuring equitable access to affordable, quality health care.

The health system is led by the **Ministry of Health,** which oversees specialized agencies and boards responsible for regulation, service delivery and professional oversight, including the National Medical Supplies Agency, the Health Service Commission and the National HIV and AIDS Commission. At the local level, **Local Councils** oversee **District Health Management Teams** for PHC, while district hospitals provide secondary care.

FIGURE 5

Health sector policies, strategies and plans

Coverage	Name	2025	2026	2027	2028	2029	2030
Health system governance & planning	**National Health and Sanitation Policy**						
	National Health Sector Strategic Plan						
	Universal Health Coverage Roadmap						
	Healthcare Financing Strategy						
	Health Sector Monitoring & Evaluation Strategy						
	National Research for Health Policy						
	National Digital Health Strategy and Roadmap						
Maternal & child health	Child Survival Action Plan						
	School Health Policy						No end date stated
	Strategy for the Reduction of Adolescent Pregnancy and Ending Child Marriage						
Nutrition & population health	National Population Policy						No end date stated
	Multi-Sectoral Strategy to Prevent and Control Anaemia	<					
	Multi Sector Strategic Plan to Reduce Malnutrition	<					
Health security & surveillance	National Action Plan for Health Security					Under development	
Public health security & surveillance	Neglected Tropical Diseases Master Plan						
Human resources	Nursing & Midwifery Strategic Plan and Strategy						
Infrastructure & equipment	Policy on Management and Maintenance of Medical Equipment and Devices						

Policy **Strategy / Strategic Plan** **Plan / Roadmap** < or > started before / ended after shown years

Health spending trends

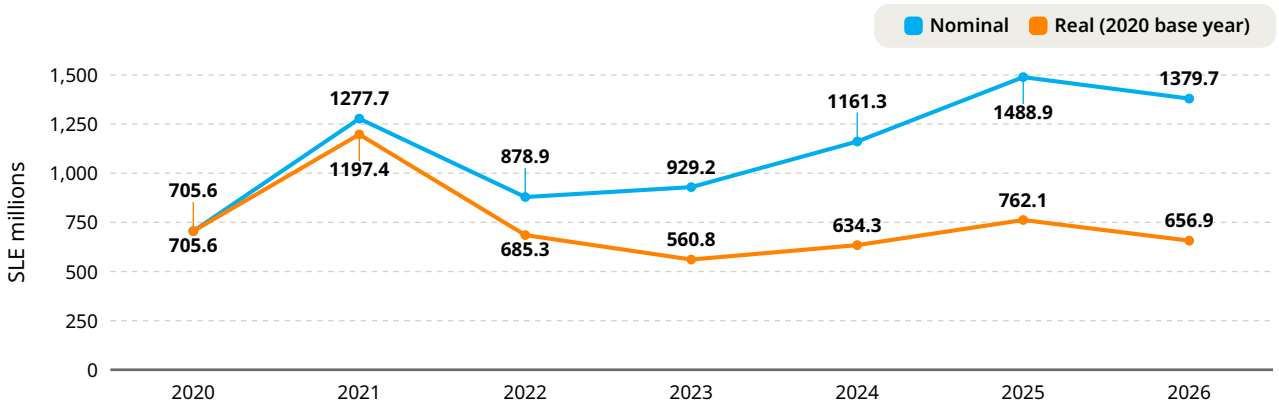
Health expenditure rose in nominal terms between 2020 and 2026 but declined in real terms, indicating an erosion of purchasing power (*see Figure 6*). The Government allocated SLE1.38 billion to health in 2026, nearly double the SLE706 million allocated in 2020. However, after adjusting for inflation, real expenditure fell to SLE656.9 million. The 2026 allocation is also 7 per cent lower than in 2025, placing renewed pressure on the sector's ability to sustain and expand essential health services.

Health spending remains well below international and national targets (*see Figure 7*). At 4.6 per cent of the national budget in 2026,[2] it is far below the Abuja Declaration target of 15 per cent. It also remains below 1 per cent of GDP – well short of the national target of 5 per cent by 2030, endorsed in the National Health Compact at the UHC Forum in December 2025. Both indicators have largely stagnated since 2021, with a slight decline between 2025 and 2026. This suggests limited prioritization of health within public expenditure and underscores the need for sustained additional investment to advance UHC and broader health sector objectives.

2. The analysis uses total government expenditure and net lending, including interest payments on public debt, as the denominator to ensure comparability across sectors and reflect the extent to which debt servicing constrains fiscal space for health. Consequently, the expenditure shares presented in this Brief may differ from those reported by the Government of Sierra Leone, which typically calculates sectoral allocations using primary expenditure (excluding interest payments). By incorporating debt servicing, the analysis provides a more comprehensive and realistic assessment of the resources available to the health sector, recognizing that debt obligations compete directly with health and other social sectors for limited public funds.

FIGURE 6

Government of Sierra Leone domestically financed nominal and real health sector spending trends, FY2020–2026 (2020 base year)

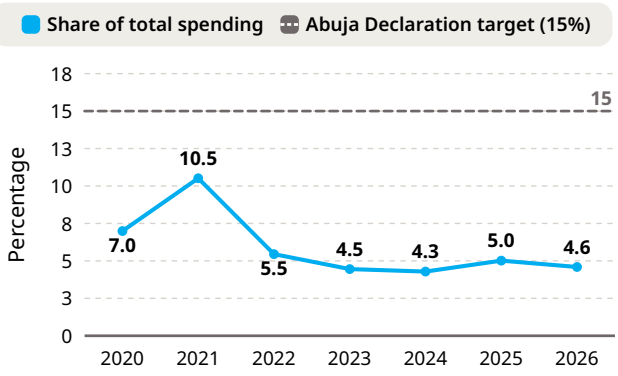


Source: Authors' calculations based on data from FY2020–2026 Budget Speech Annexes and Annual Public Accounts, complemented by data from the Ministry of Finance.
Note: Data for FY2020–2024 data are actual expenditures, for FY2025 are budget estimates, and for FY2026 are approved allocations. Only on-budget, domestically financed budget data are included. Inflation is calculated from the GDP deflator extracted from Budget Speeches, with 2020 as the base year.

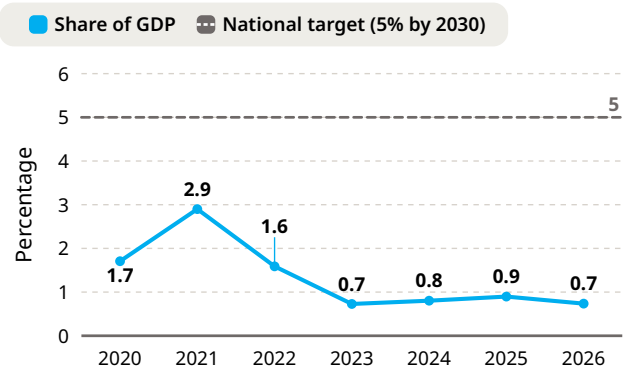
FIGURE 7

Government of Sierra Leone health sector spending as a proportion of total spending and GDP, 2020–2026

a: Share of total government spending



b: Share of GDP

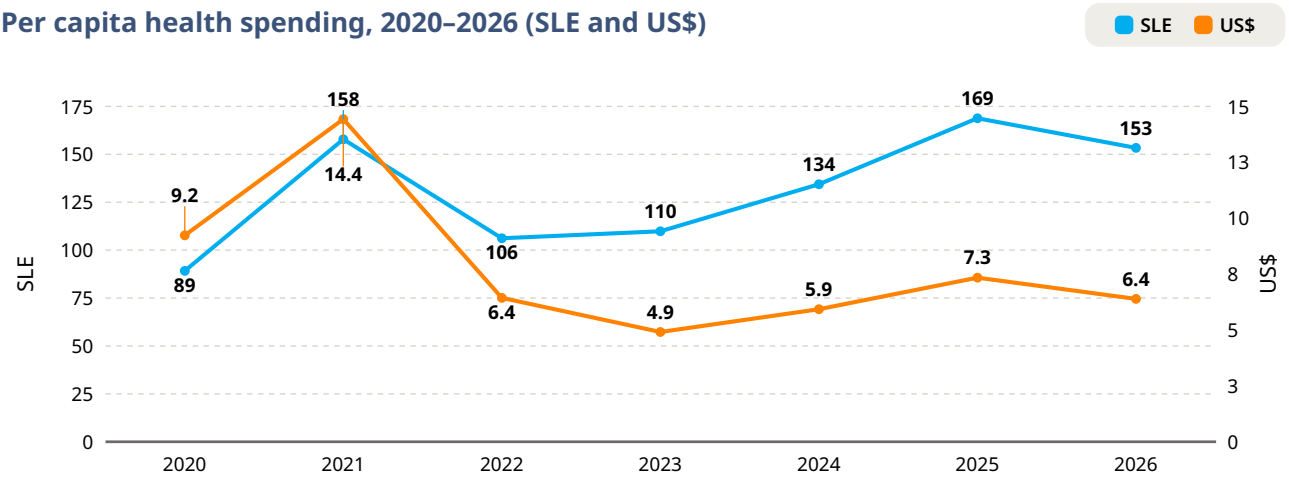


Source: Authors' calculations based on data from FY2020–2026 Budget Speech Annexes and Annual Public Accounts, complemented by data from the Ministry of Finance.
Note: Data for FY2020–2024 are actual expenditures, for FY2025 are budget estimates, and for FY2026 are approved allocations. Only on-budget domestically financed budget data are included.

Per capita health spending increased in local currency terms between 2020 and 2026, but gains were eroded by inflation and exchange rate depreciation (*see Figure 8*). It rose from SLE89 in 2020 to SLE153 in 2026 but fell between 2025 and 2026 in both Leone and US dollar terms. In US dollar terms, per capita spending fell from US$9.2 in 2020 to US$6.4 in 2026, underscoring the limited purchasing power available to finance health services despite nominal increases.

FIGURE 8

Per capita health spending, 2020–2026 (SLE and US$)



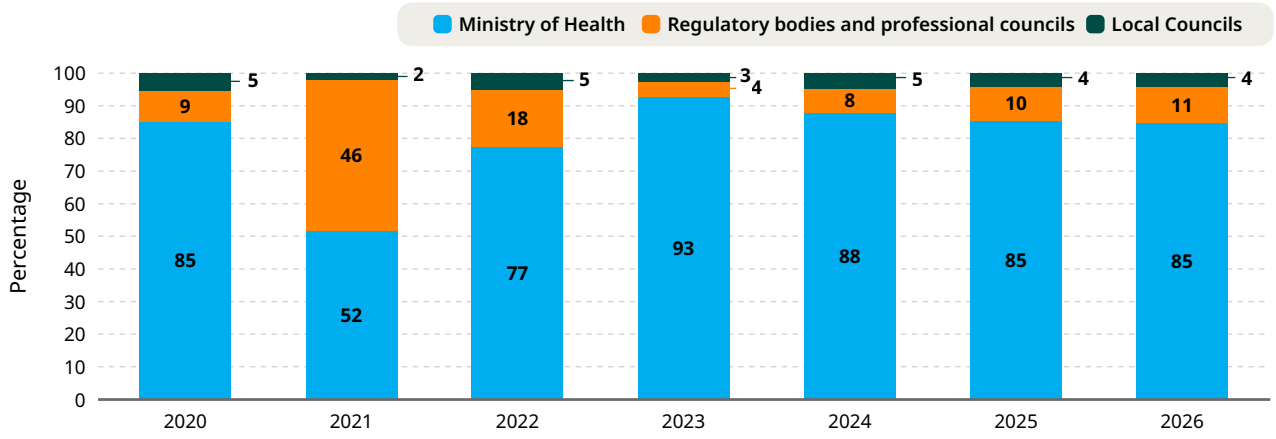
Source: Authors' calculations based on data from FY2020–2026 Budget Speech Annexes and Annual Public Accounts, complemented by data from the Ministry of Finance. Population data from UN World Population Prospects.
Note: Data for FY2020–24 are actual expenditures, for FY2025 are budget estimates, and for FY2026 are approved allocations. Only on-budget, domestically financed budget data are included.

Composition of health spending

The Ministry of Health dominates health sector spending, accounting for around 85 per cent of total expenditure between 2020 and 2026 (*see Figure 9*). The National Medical Supplies Agency and, more recently, the National Public Health Agency were the next largest spending institutions. Other agencies, including the Health Service Commission, Pharmacy Board Services and the National HIV and AIDS Commission, each received less than 2 per cent of annual government health expenditure. The COVID-19 pandemic temporarily altered this pattern: in 2021, expenditure through the National COVID Emergency Response Centre (NaCOVERC) accounted for 38 per cent of total health sector spending.

FIGURE 9

Composition of health spending by institution, FY2020–2025



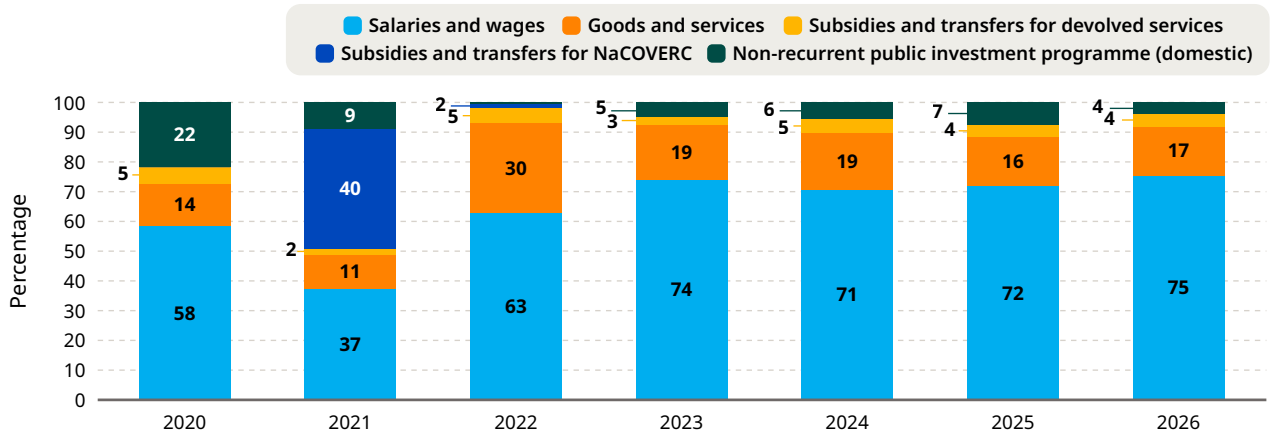
Source: Authors' calculations based on data from FY2020–2026 Budget Speech Annexes and Annual Public Accounts, complemented by data from the Ministry of Finance.
Note: Data for FY2020-24 are actual expenditures, for FY2025 are budget estimates, and for FY2026 are approved allocations. Only on-budget, domestically financed budget data are included. National health sector regulatory bodies, statutory agencies and professional councils include the National Medical Supplies Agency, the Dental and Medical Board, the Health Service Commission, the National HIV and AIDS Commission, the Teaching Hospitals Complex Administration, the Post Graduate College of Health Specialists, the National Public Health Agency, Pharmacy Board Services and the Allied Health Professions Council.

The overwhelming majority of health spending is recurrent, averaging more than 90 per cent of total health expenditure between 2020 and 2026 (*see Figure 10*). Salaries and wages accounted for the largest share, averaging over 60 per cent of expenditure, while goods and services fluctuated between 11 and 30 per cent. Subsidies and transfers to devolved services ranged from 4 to 13 per cent and have declined since 2022. This composition limits fiscal space for capital investment and decentralized service delivery, constraining the sector's ability to expand infrastructure, strengthen front-line services and build long-term health system resilience.

In 2025, nursing professionals accounted for nearly half of health workforce salary expenditure (*Figure 11*). Generalist medical practitioners accounted for 14 per cent, and community health workers for 10 per cent, while mid-level, specialized and technical cadres, including laboratory technicians, pharmacists and specialist medical practitioners, received a smaller proportion. This salary distribution broadly reflects the current workforce structure, but it also highlights the need to align payroll expansion with strategic workforce planning to address critical skills gaps and support more balanced service delivery.

FIGURE 10

Composition of health spending by economic classification, FY2020–2026



Source: Authors' calculations based on data from FY2020–2026 Budget Speech Annexes and Annual Public Accounts, complemented by data from the Ministry of Finance.
Note: Data for FY2020–2024 are actual expenditures, for FY2025 are budget estimates, and for FY2026 are approved allocations. Only on-budget, domestically financed budget data are included.

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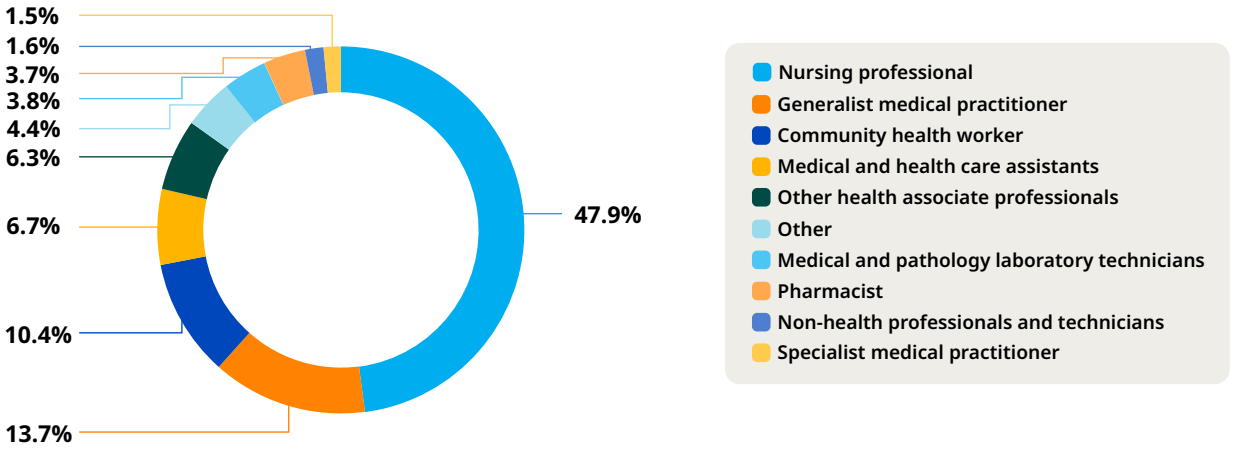
FIGURE 11

Composition of health workforce monthly salary expenditure by occupation, 2025



Source: Authors' calculations based on data obtained from the Ministry of Health.
Note: The data reflect monthly salaries only and do not include allowances or other benefits. Occupational groups are based on the WHO's international classification of health workers (World Health Organization, 'Classifying health workers: Mapping occupations to the International Standard Classification', WHO, Geneva, 2019, <https://cdn.who.int/media/docs/default-source/health-workforce/dek/classifying-health-workers.pdf>.

Budget credibility and execution

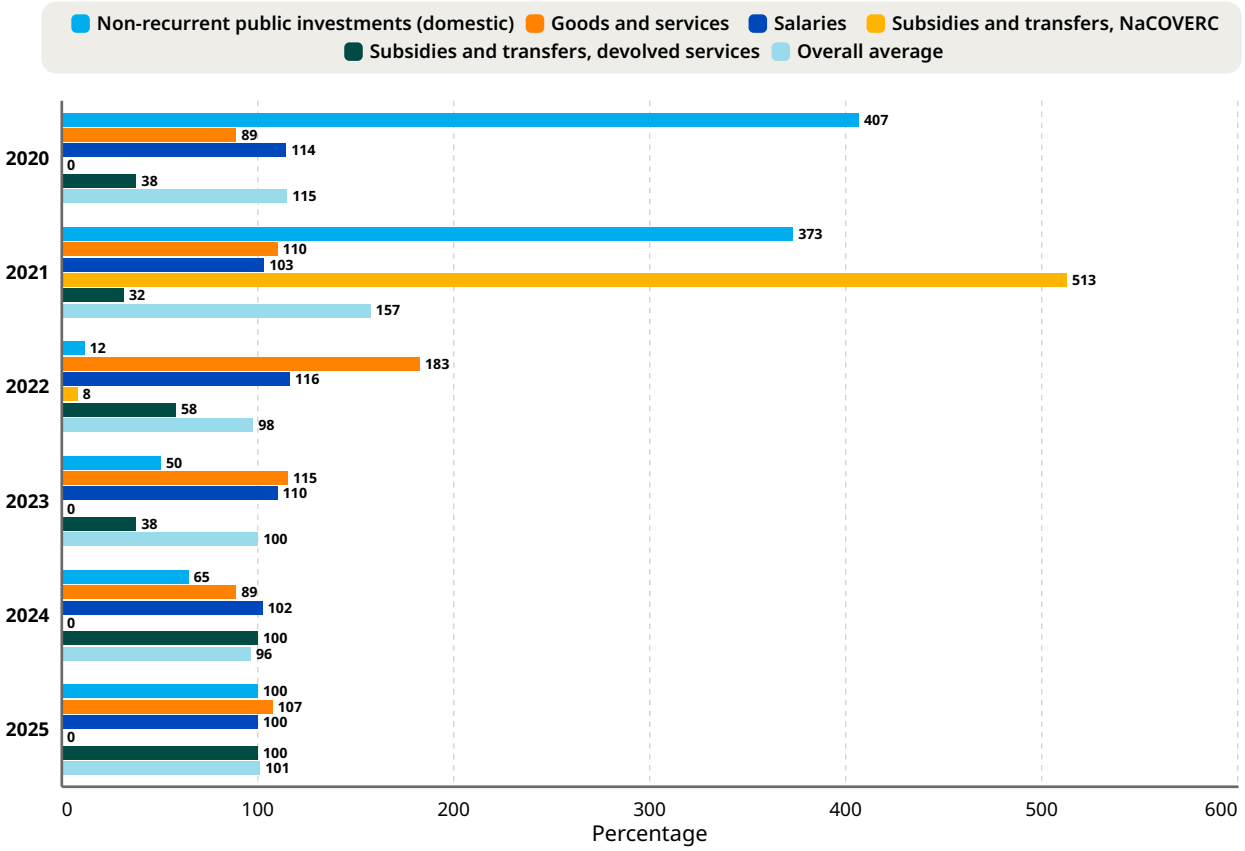
The health budget execution rate has averaged around 100 per cent in recent years (*see Figure 12*). This suggests that, at aggregate level, allocated funds have generally been spent. However, this aggregate performance masks volatility during the COVID-19 period, when the sector experienced significant overspending in 2020–2021.

Disaggregated execution data show significant variation across spending categories and institutions between 2020 and 2025. Capital spending remained weak and volatile, moving from an early overspend to a sharp underspend before stabilizing in 2025. Recurrent spending – particularly on salaries – was executed at or above budget, reflecting sustained payroll and operational pressures.

Transfers to devolved services were consistently underspent until 2023, before reaching full execution in 2024 and 2025. At institutional level, the Ministry of Health moved from persistent overspending to nearly full execution, while the National Medical Supplies Agency recorded marked volatility, with an overspend in 2022 followed by a significant underspend from 2023 onwards. The National Public Health Agency also recorded very high execution in 2024 and 2025, likely reflecting start-up costs following its establishment in 2023. These patterns suggest that strong aggregate execution masks underlying weaknesses in planning, commitment control, cash-flow management and the alignment of spending with approved priorities.

FIGURE 12

Budget execution rates by economic classification, FY2020–2025



Source: Authors' calculations based on data from FY2020–2026 Budget Speech Annexes and Annual Public Accounts, complemented by data from the Ministry of Finance.
Note: Data for FY2020–2024 are actual expenditures, for FY2025 are budget estimates, and for FY2026 are approved allocations. Only on-budget domestically financed budget data are included.

TABLE 2

Budget execution rates (%) by budget agency, FY2020–2025 (excluding NaCOVERC transfers)

	2020	2021	2022	2023	2024	2025
Ministry of Health	139	124	125	114	101	101
National Medical Supplies Agency	93	84	141	15	24	37
Dental and Medical Board	10	47	0	85	90	65
Health Service Commission	48	55	95	119	99	89
National HIV and AIDS Commission	63	55	104	98	80	95
Teaching Hospitals Complex Administration	29	188	113	81	49	89
Post Graduate College of Health Specialists	47	101	66	111	84	92
National Public Health Agency	–	–	–	–	360	254
Pharmacy Board Services	87	82	98	88	61	82
Allied Health Professions Council	–	–	–	–	–	50
Devolved Health services to local councils	38	32	58	38	100	100
Transfers to NaCOVERC	–	513	8	–	–	–

Source: Authors' calculations based on data from FY2020–2026 Budget Speech Annexes and Annual Public Accounts, complemented by data from the Ministry of Finance.
Note: Data for FY2020–2024 are actual expenditures, for FY2025 are budget estimates, and for FY2026 are approved allocations. Only on-budget, domestically financed budget data are included.

Decentralization of health spending

Under the Local Government Act 2004, primary and secondary health-care services are formally devolved to Local Councils. However, several core health system functions remain centrally managed, including medical supply chains through the National Medical Supplies Agency, creating a mixed, decentralized–centralized delivery architecture.

Local Councils remain highly dependent on central government transfers, which financed more than 90 per cent of local service delivery between 2018 and 2022. There is limited own-source revenue directed to the health sector. Transfers to Local Councils are managed through agreed formulas and are expected to be disbursed quarterly by the Ministry of Finance. In practice, however, Local Councils have limited discretion over the timing, volume and use of resources. At service delivery level, PHC is implemented through District Health Management Teams, while secondary care is delivered through hospitals that operate as separate accounting units. This arrangement places Local Councils at the centre of front-line service delivery, but with constrained fiscal autonomy, limited control over key inputs and weak leverage to address service delivery gaps.

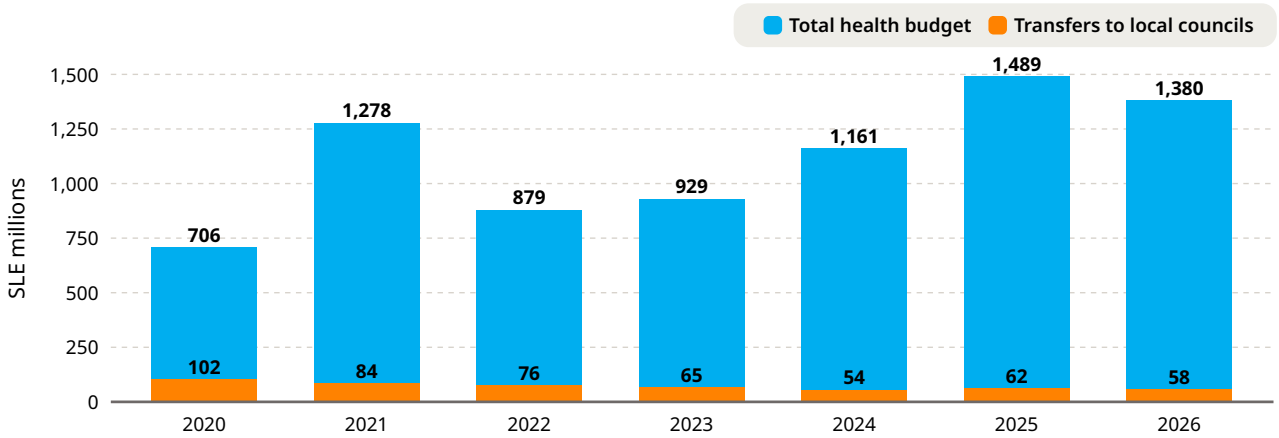
Despite growth in the overall health budget, transfers to Local Councils for devolved health services declined sharply from SLE102 million in 2020 to SLE58 million in 2026 (*see Figure 13*). This represents a decrease in the proportion of the total health budget from approximately 14 per cent to around 4 per cent, indicating a significant reduction in resources available for decentralized health service delivery and front-line PHC functions.

Transfers to Local Councils are also frequently delayed, unpredictable and below approved budgets, with execution rates generally below 50 per cent between 2018 and 2022. This weak and unreliable financing undermines local planning, disrupts service delivery and limits Local Councils' ability to respond to district-level health priorities. Own-source revenue remains constrained by administrative inefficiencies, legal ambiguities, and disputes between Local Councils and chiefdom authorities over collection rights, despite reforms such as property tax systems and revenue mobilization strategies.

Although the Government's administrative classification limits detailed analysis by level of care, the low and declining allocation to Local Councils points to a likely underfunding of PHC, despite the Government's stated commitment to UHC. This creates a disconnect between policy commitments and the financing available for front-line prevention, health promotion and basic service delivery.

FIGURE 13

National and subnational spending trends in the health sector, FY2020–2026



Source: Authors' calculations based on data from FY2020–2026 Budget Speech Annexes and Annual Public Accounts, complemented by data from the Ministry of Finance.
Note: Data for FY2020–2024 are actual expenditures, and for FY2025 and FY2026 are approved allocations. Only on-budget, domestically financed budget data are included.

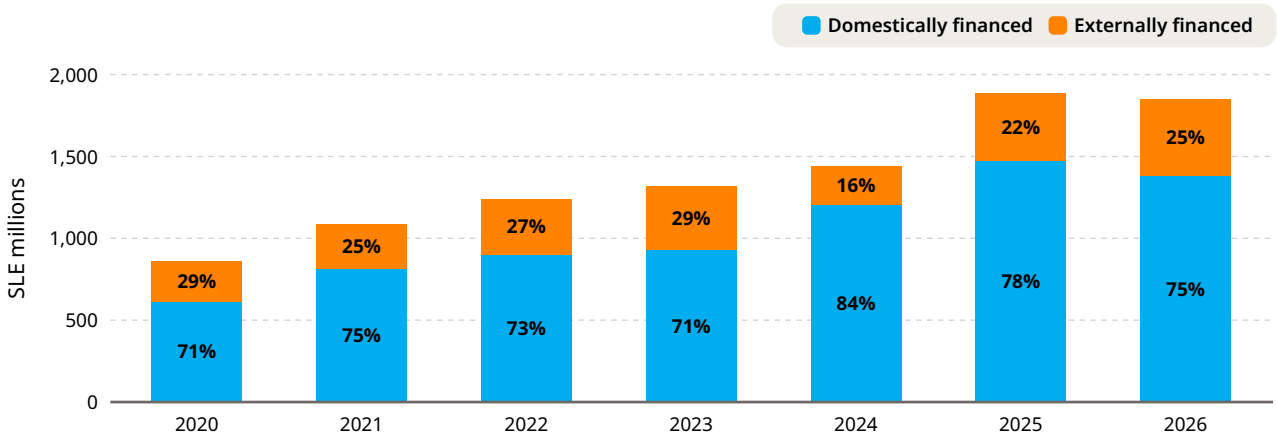
Overall, health sector decentralization remains constrained by incomplete devolution, fragmented responsibilities, weak coordination between central and local levels, and inconsistent funding flows. Strengthening PHC financing, clarifying institutional responsibilities and ensuring timely and predictable transfers are therefore essential to improving disease prevention, health promotion and equitable front-line service delivery.

Health financing

Domestic financing accounts for 75 per cent of the on-budget health allocation, but donor resources still represent a significant proportion at 25 per cent (*see Figure 14*). On-budget donor allocations declined notably in 2024, underscoring the volatility of external support. However, on-budget figures capture only part of the financing picture and understate total donor support, much of which is channelled off budget through projects and programmes managed by implementing partners. This financing structure points to the need for stronger fiscal sustainability, greater predictability and closer alignment of all health resources with national priorities.

FIGURE 14

Health external vs. domestic budget allocations (on budget), 2020–2026



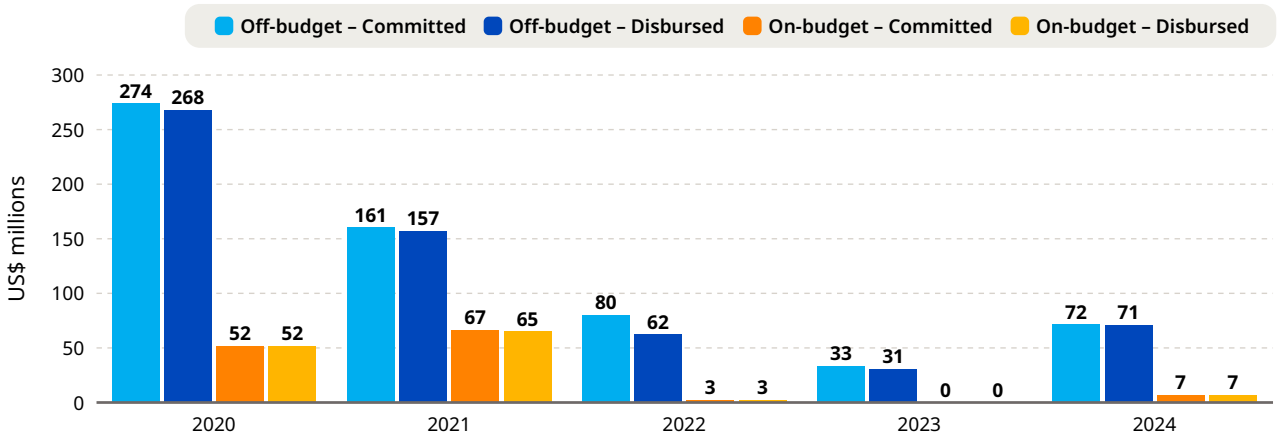
Source: Authors' calculations based on data from FY2020–2026 Budget Speech Annexes and Annual Public Accounts, complemented by data from the Ministry of Finance.
Note: The data capture approved allocations only. Only on-budget data are included.

Development partners provide substantial health financing, but most external resources are managed outside government budget systems and implemented directly through partners (*see Figure 15*). DAD Sierra Leone data for 2020–2024 show that donor financing remains predominantly off budget, while both on- and off-budget donor funding declined over the period. Off-budget financing averaged 88 per cent of total external health funding, compared with only 12 per cent recorded on budget (*see Figure 16*). This limits the visibility of total sector resources and weakens the ability to plan, coordinate and prioritize financing across programmes.

Heavy reliance on external resources exposes the health sector to funding volatility, fragmentation and weak accountability. Strengthening domestic resource mobilization and increasing the share of external support recorded on budget are therefore critical to sustaining health programmes and aligning financing with UHC priorities. Parallel funding structures weaken coordination because ministries, departments and agencies do not consistently report donor funds received outside government systems, limiting oversight and contributing to fragmented implementation, duplication risks and inefficiencies.

FIGURE 15

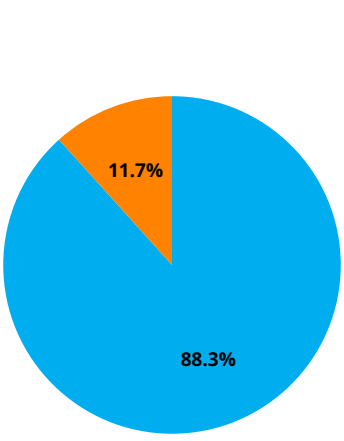
Committed and disbursed on- and off-budget external health sector financing, 2020–2024



Source: Government of Sierra Leone, 'DAD Sierra Leone', 2026, <https://dad.synisys.com/dadsierraleone>.

FIGURE 16

Average share of on- and off-budget external health sector financing, 2020–2024

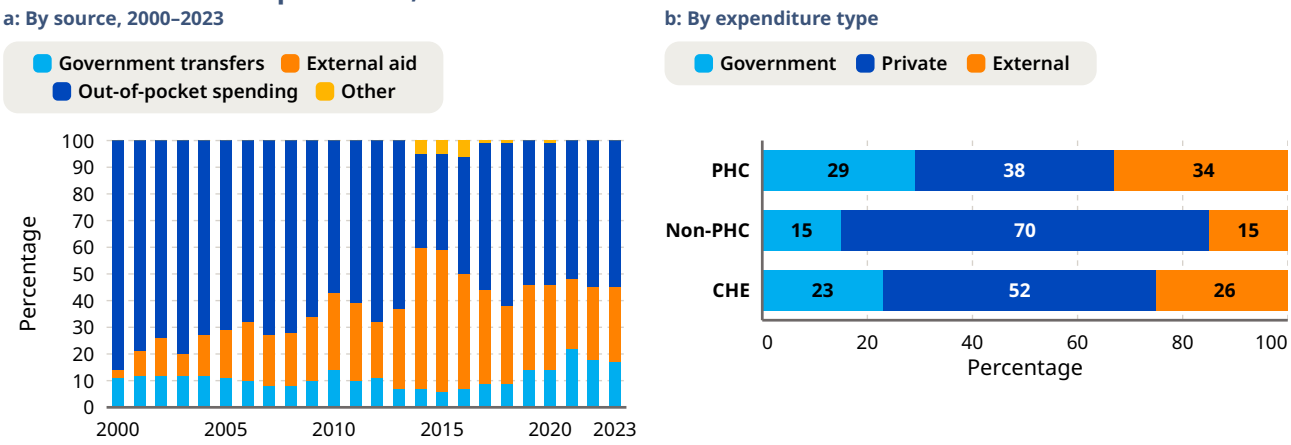


Source: Government of Sierra Leone, 'DAD Sierra Leone', 2026, <https://dad.synisys.com/dadsierraleone>.

When off-budget expenditure is included, government spending accounts for only a small share of Sierra Leone's total health expenditure. Data from the WHO Global Health Expenditure Database show that public financing remains a small source of total health spending (*see Figure 17*). In 2023, out-of-pocket payments were the largest source, accounting for more than half of total health expenditure, followed by external financing, while government expenditure ranked third at less than 20 per cent. This financing pattern raises serious equity and financial protection concerns, as households continue to bear a large proportion of health costs directly. Expanding pooled public financing is therefore essential to reduce households' financial burden, improve equity and support progress towards UHC.

FIGURE 17

Sources of health expenditure, 2000–2023



Source: WHO Global Health Expenditure Database.
Note: PHC: Primary health care (expenditure); CHE: Current health expenditure.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