MINISTRY OF HEALTH
GOVERNMENT OF SIERRA LEONE

Directorate of Reproductive and Child Health

300 Days of Activism for Triple Zero

COMPREHENSIVE PROGRESS REPORT AT DAY 150

July 2026



Zero Preventable Maternal Deaths

Zero Preventable Child Deaths

Zero Zero-dose Children

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Abbreviations and Acronyms

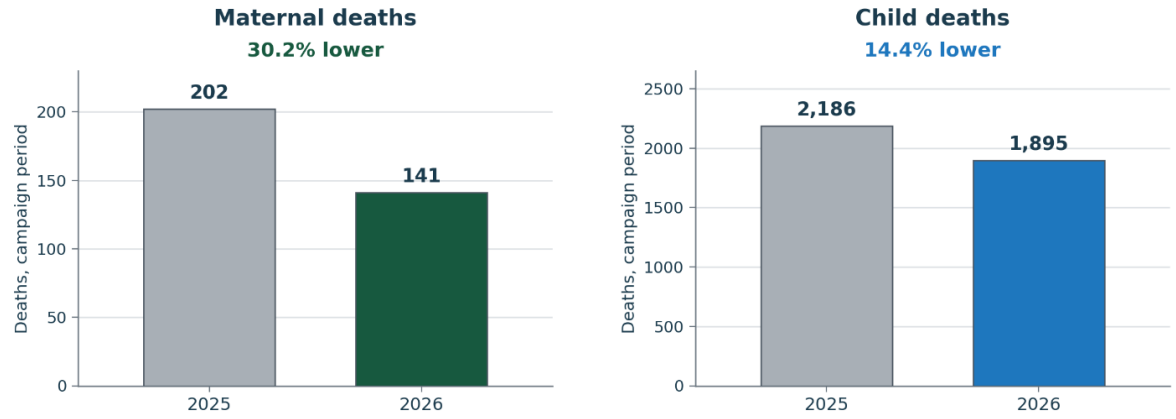
Term	Meaning	Term	Meaning
ANC	Antenatal Care	MCHP	Maternal and Child Health Post
BEmONC	Basic Emergency Obstetric and Newborn Care	MPDSR	Maternal and Perinatal Death Surveillance and Response
CEmONC	Comprehensive Emergency Obstetric and Newborn Care	NEMS	National Emergency Medical Service
CHC	Community Health Center	NMSA	National Medical Supplies Agency
CHO	Community Health Officer	NPHA	National Public Health Agency
CHP	Community Health Post	NSBS	National Safe Blood Service
CHW	Community Health Worker	PCMH	Princess Christian Maternity Hospital
DHMT	District Health Management Team	PHU	Peripheral Health Unit
DMO	District Medical Officer	PNC	Postnatal Care
DHS	District Health Sister	RCH / DRCH	Reproductive and Child Health and its directorate
EmONC	Emergency Obstetric and Newborn Care	RCCE	Risk Communication and Community Engagement
EPI	Expanded Programme on Immunisation	RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
ETAT	Emergency Triage, Assessment, and Treatment	SCBU	Special Care Baby Unit
FHC	Free Health Care	SECHN	State Enrolled Community Health Nurse
IPC	Infection Prevention and Control	ODCH	Ola During Children's Hospital
MoICE	Ministry of Information and Civic Education	PPH	Postpartum Haemorrhage
DALY	Disability-Adjusted Life Year	ITS	Interrupted Time Series
DPPI	Directorate of Policy, Planning and Information	DHRH	Directorate of Human Resources for Health
MCOE	Maternal Centre of Excellence	UBC	United Brethren in Christ

Part 1. Executive Summary

At the midpoint of the campaign, the direction of travel is clear and positive, held back only in a small number of places we already know by name. Since the campaign was launched on 1st March 2026, the country has recorded 141 maternal deaths during the campaign months, compared to 202 in the same weeks of 2025. This means that 61 mothers who would have died last year are alive today. Child deaths during the same period total 1,816, compared to 2,121 a year earlier, representing a decrease of 305. Both reductions come from the same weekly district reporting the campaign has used since Week 1.

The campaign at a glance

Where we stand at Day 150	The number	What it means
Maternal deaths, campaign period	141 against 202	61 fewer mothers were lost, down 30.2 per cent.
Child deaths, campaign period	1,816 against 2,121	305 fewer children were lost, down 14.4 per cent.
Estimated lives saved so far	592	Roughly one every six hours
Zero-dose children reached	7,117 of 9,006	79.0 per cent reached, with 1,889 still to find
Districts improving	14 of 16	Only Bo and the Western Area Urban recorded more deaths than last year.
Maternal reduction, strength	Very unlikely to be by chance	Significant at a probability of 0.022



Source: DRCH line lists, comparable reporting weeks (1 March to 19 July)

Figure 1: *Maternal and child deaths in the campaign period against the same weeks of 2025.*

Measured against what the earlier trend and seasonality would have produced, the campaign has directly averted 366 deaths and indirectly averted 226 deaths over 150 days. That is close to one life saved every six hours, twenty-nine every week, a mother every two to three days, and a child

every twelve hours. When a mother is saved, it is not one life but a household that is spared; on our estimate, using a total fertility rate of about 3.7 births per woman [1], some 226 children still have their mother because of this work.

The maternal reduction of about 30 per cent over the campaign is statistically significant. An interrupted time series analysis indicates a step fall of roughly 3.2 maternal deaths per week from the week of launch, with a probability of 0.022 that this change arose by chance, and the finding holds when the series is modelled with ARIMA [2]. The child reduction is smaller, but its shape is more encouraging. Rather than a single step, it is a bending trend that widens as the weeks pass, which is how newborn care, nutrition, and immunisation are expected to show up in the mortality figures.

On zero-dose immunisation, 7,117 of the 9,006 children identified as never having received a single vaccine have now been reached and vaccinated, which is 79.0 per cent of the target. The 1,889 children still outstanding are the hardest to find and reaching them is the clearest test of whether the campaign can move from a satisfactory number toward zero.

None of this should be read as a finished job. Preventable deaths continue every week, and the reductions, though real, are not yet at a level any of us would call safe. Fourteen of the sixteen districts have recorded the same or fewer maternal deaths than in the same period last year. The two exceptions, Bo and the Western Area Urban, are where the campaign is now concentrating supervision, referral audits, blood support, and accountability.

The first 150 days have shown the country exactly where its remaining deaths are coming from and how to stop them: a few hospitals with many cases, delays in care after a woman arrives at a facility, two areas going against the trend, hard-to-reach unvaccinated children, and ongoing issues with commodities, blood supply, referrals, and paperwork. Behind the headline figures sits a large body of work. This report documents in full the strengthening of hospitals and specialised units; a decentralised blood service; free health care medicines moved to the last mile; health worker recruitment; supportive supervision of primary health care; weekly death reviews; community mobilisation together with the Ministry of Information and Civic Education; and a growing research effort. The central message is the one the Honourable Minister set: the target is not a better number but zero, and this report is an account of how far along that road the country is and what remains to be done.

Part 2. Background and Context

2.1 Why the campaign was mounted

The campaign must be viewed in the context of Sierra Leone's high rates of maternal and child deaths, which rank among the highest in the world. The most recent United Nations inter-agency estimates put the country's maternal mortality ratio at 354 deaths per 100,000 live births in 2023, down from 1,682 in 2000 and 443 in 2020 [3]. That fall over a generation is real and hard-won, but the level that remains is still among the highest anywhere, and the country's own 2019 Demographic and Health Survey, which measures deaths directly rather than by model, recorded a ratio of 717 per 100,000 [20], a reminder that the true burden a campaign has to prevent may be greater than the modelled series suggests. On the child side in Sierra Leone, the picture is the same in shape: the latest UN IGME estimates (2023) recorded an under-five mortality rate of 109.3 deaths per 1,000 live births and a neonatal mortality rate of 28.8 per 1,000 live births [4], at a time when the global under-five rate was 38.3 and the neonatal rate 17.8 [5]. A child born in Sierra Leone still begins life at several times the average risk of a child elsewhere.

Behind those ratios sit causes that are, for the most part, both known and preventable. Globally and in Sierra Leone, the leading direct causes of maternal death are haemorrhage, hypertensive disorders of pregnancy, and sepsis [6], and the leading causes of death in children under five are preterm birth complications; intrapartum events, including birth asphyxia; pneumonia; malaria; diarrhoea; and neonatal sepsis, with undernutrition an underlying factor in a large share [7]. These are the same conditions that dominate the campaign's own death reviews. Sierra Leone is not, in other words, facing an unusual set of killers. Sierra Leone is facing ordinary killers, and the campaign was designed to answer the question of why women and children continue to die from conditions that medicine has long known how to treat.

Fertility compounds the stakes. With a total fertility rate of around 3.7 to 4.2 births per woman [1], each Sierra Leonean woman faces the risks of pregnancy and delivery several times over a lifetime, and each maternal death removes a mother from a household that, on average, contains several dependent children. The country has also, since 2010, guaranteed free health care at the point of use for pregnant women, lactating mothers, and children under five through the Free Health Care Initiative [8], which means the remaining deaths are, increasingly, not a problem of whether care is paid for but of whether it is available, timely, and of adequate quality when a woman or child reaches it.

2.2 The triple-zero rationale and the "one delivery problem" logic

The 300 Days of Activism for Triple Zero was launched to move the country from counting maternal and child deaths to preventing the next one. Its three goals are simple to state and hard to reach: zero preventable maternal deaths, zero preventable child deaths, and zero children who have never received a single vaccine, the last of these being the "zero-dose" children that global immunisation strategy now treats as the sharpest marker of an unreached population [9]. The campaign sits inside the ministry's wider commitment to human capital development.

Its central design choice is to treat maternal survival, child survival, and immunisation not as three separate programmes but as one delivery problem with shared bottlenecks. This is the campaign's

own analytical position, and it is borne out by the death reviews: a woman who bleeds to death and a child who dies of measles are often failed by the same weak referral, the same empty shelf, and the same delayed decision. The classic account of why women die even when the means to save them exist, the “three delays” of deciding to seek care, reaching a facility, and receiving adequate care once there [10], applies with equal force to a sick child, and the campaign has used it as a common frame across all three zeros. Treating the three goals as one problem is what allows a single weekly cycle, a single set of district task forces, and a single line-list discipline to serve all of them at once.

2.3 How the campaign is run: governance and the weekly cycle

The design deliberately avoided treating the campaign as a communications event. From the outset, it was run as a coordination platform with weekly national and district performance reviews, activated district task forces, strengthened maternal and perinatal death surveillance and response, and real-time monitoring of a short set of indicators that the MoH leadership looks at each week.

The engine of the campaign is a weekly cycle that is now routine. Each week the districts report maternal deaths, child deaths and admissions, immunisation progress, and the actions owed from previous weeks. The coordination unit thoroughly examines the data, identifies red flags, investigates the causes of each death and their preventability, verifies the district’s review, and monitors the completion of the agreed-upon corrective actions. A weekly situation brief carries the picture back to leadership in a form that can be read in minutes. This rhythm, more than any other single factor, has driven the numbers, and it is the most cost-effective aspect of the campaign to maintain because the necessary structures are already in place.



Photo 1: *National weekly performance review in session, coordinating unit situation room, Freetown*



Photo 2: *Bo District health management team reviewing its weekly data at a district situation room*

The coordination unit is deliberately positioned as a problem-solving and response platform, not a reporting desk. Its job is to interpret patterns, identify where support is needed, mobilise technical and partner help, and escalate the bottlenecks that a district cannot clear on its own. Underneath it sit sixteen district taskforces, each meeting in a situation room and each expected to answer, every week, a fixed set of questions: how many mothers and children died; where; from what causes; with what delay; whether the death was reviewed; what action was agreed upon; who is responsible; and what has actually been done. A district reporting several deaths in a week receives a direct check-in rather than a circular. The point of this architecture is accountability that runs in both directions: districts are asked to interpret their own data and own their own

bottlenecks, and the centre, in turn, is expected to unblock the things only it can, from specialist staffing to blood logistics to commodity supply.

It is worth being clear about why the weekly cadence matters so much to a goal of zero. A monthly or quarterly rhythm allows a problem to run for weeks before anyone acts; a weekly rhythm catches a deteriorating facility, a stock-out, or a cluster of deaths while there is still time to intervene. The strengthened death review at the heart of the cycle is the country's application of maternal and perinatal death surveillance and response, the internationally recommended discipline of reviewing every death to identify and act on what could have prevented it [11]. The campaign has effectively reduced the time between the emergence of a problem and the system's response, and this reduction is contributing significantly to each of the improvements reported. The aim of the second half is to make this rhythm so ordinary that it no longer feels like a campaign activity at all but simply how the health system runs.

2.4 The diagnostic work of the first 100 days

The opening 100 days did the diagnostic work that the current phase is built on. They established the national coordinating unit and a functioning situation room, activated all sixteen district task forces, instituted weekly data and performance reviews, strengthened mortality surveillance, and set up the whole-of-government coordination that lets the campaign reach beyond the health sector. Regional engagement meetings in Makeni and Bo built shared understanding and district ownership. Maternal death case reviews began to look closely at the story behind each death rather than counting deaths alone, and weekly leadership briefs created a steady rhythm of reporting and decision-making. By the end of that phase, the campaign had shifted the national conversation from the general reporting of deaths to a more deliberate examination of why deaths occur, where they occur, what delays contribute, and what each district must do differently.

The first 100 days also exposed gaps that were already present in the system but not always visible in routine reporting: delayed referral decisions, weak monitoring after operations, limited blood readiness, incomplete implementation of death review recommendations, poor documentation, and weak community recognition of danger signs. Naming these plainly was the point. Since then, the focus has been on closing them, and the rest of this report details that work.

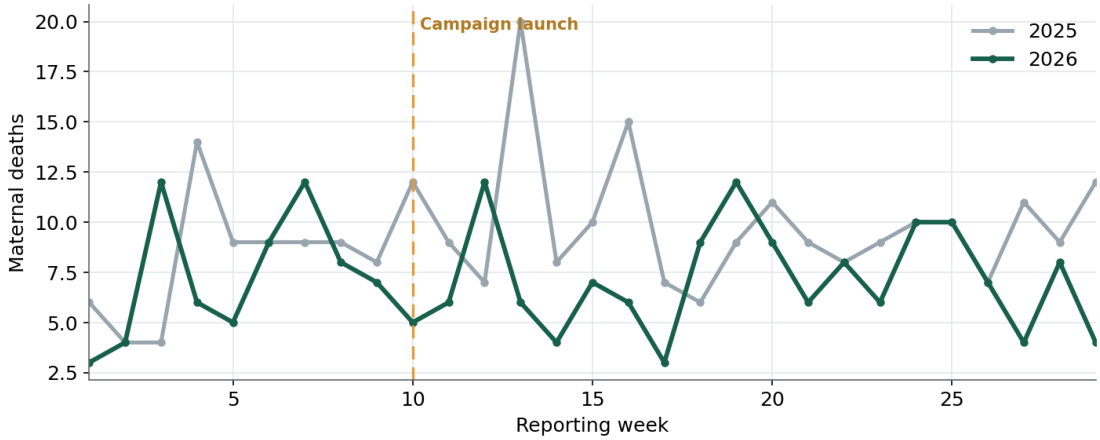
Part 3. Campaign Activities and Achievements

This section is organised by the parts of the health system that carried out the implementation. Each category begins with the achievements and supporting evidence, directing readers to the annex for verification of the underlying figures. Except where an external source is cited, every number in this part is the campaign's own, drawn from the district line lists, the child health weekly returns, the EPI tracking, and the weekly situation briefs.

3.1 Mortality and coverage results at Day 150

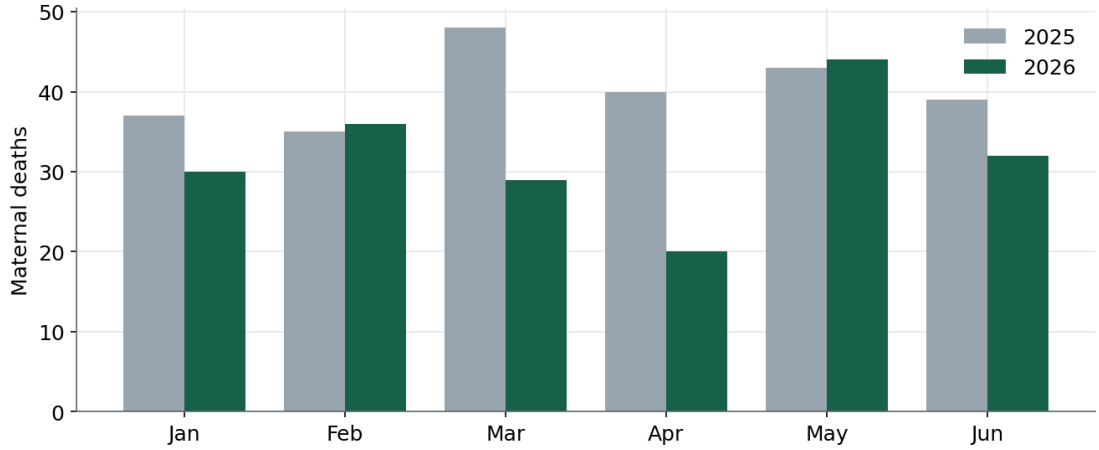
Maternal mortality

During the campaign period, from the start of March through Week 29, the country recorded 141 maternal deaths against 202 in the same weeks of 2025, a reduction of 61 deaths or 30.2 per cent. The comparison is like-for-like, week for week, and draws on the district line lists that feed the weekly situation brief.



Source: DRCH weekly maternal death line list, Weeks 1 to 29

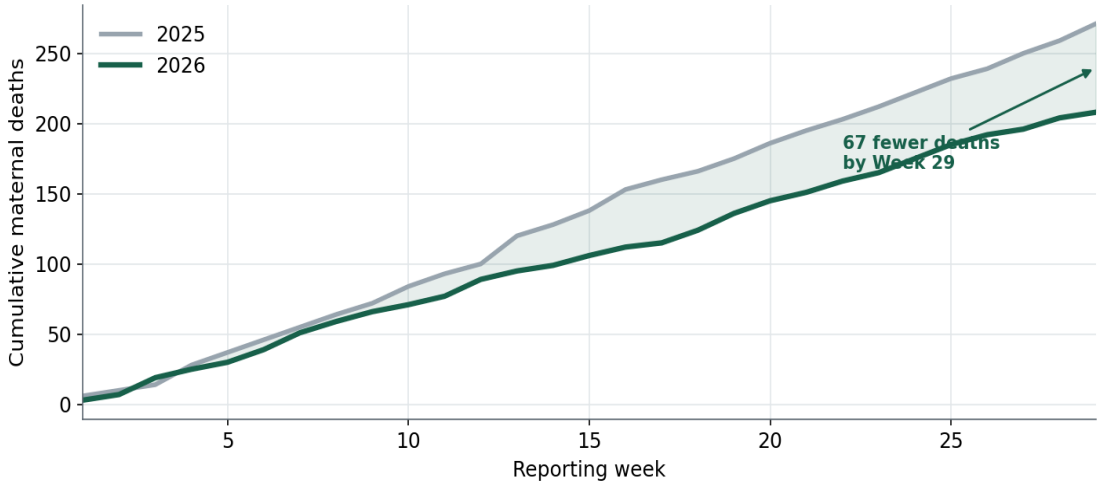
Figure 2: *Weekly maternal deaths, 2026 against 2025.* National totals by reporting week; the campaign months sit below last year almost throughout.



Source: DRCH weekly maternal death line list aggregated by month

Figure 3: *Maternal deaths by month, 2026 against 2025.*

Week 29, covering 13 to 19 July, recorded 4 maternal deaths in the Western Area Urban, which reported two, and Pujehun and Kono, which reported one each. The four most recent weeks read 7, 4, 8, and 4, the kind of movement that reinforces why single weeks must never be read in isolation.

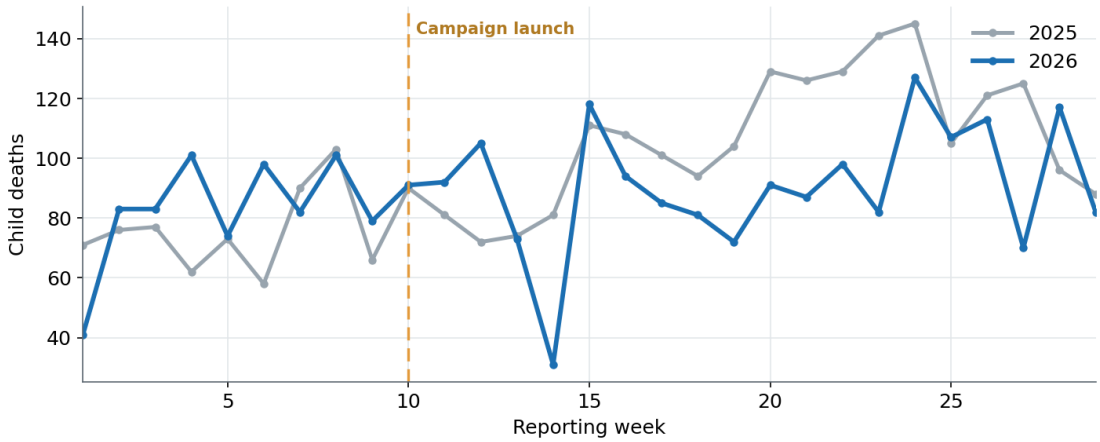


Source: DRCH weekly maternal death line list

Figure 4: *Cumulative maternal deaths. The shaded area is the running gap between the two years.*

Child survival

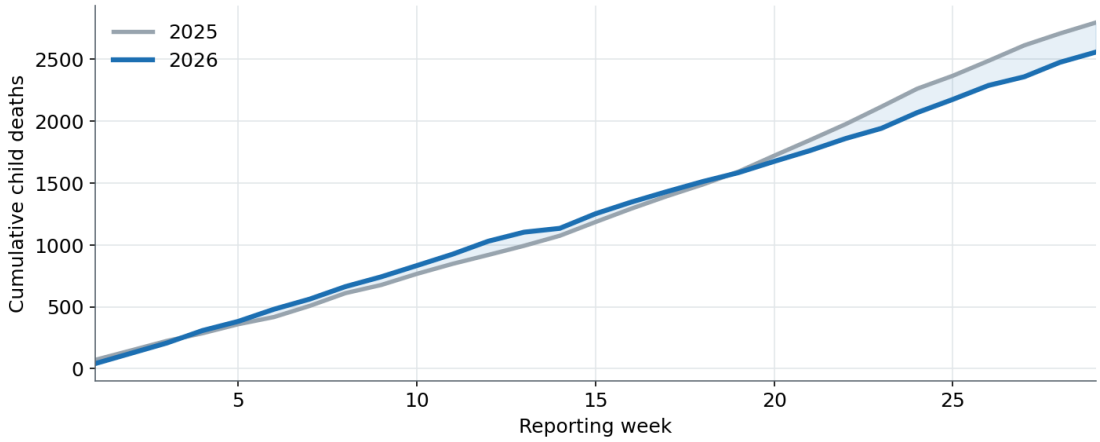
Child deaths across the campaign period stand at 1,816, compared to 2,121 in the same weeks last year, a reduction of 305 deaths, or 14.4 per cent. Week 29 recorded 82 child deaths among 1,527 admissions to the reporting hospitals, a facility mortality of about 5 per cent. The four most recent weeks read 113, 70, 117, and 82, which again cautions against reading any single week as a trend.



Source: DRCH child health weekly returns, Weeks 1 to 29

Figure 5: *Weekly child deaths, 2026 against 2025.* National totals by reporting week; the gap widens as the campaign months progress.

The child reduction is more modest than the maternal one, and that is expected. Child survival depends on slower-moving factors such as better newborn care, earlier treatment of malaria, sepsis, and pneumonia, the provision of oxygen where needed, and improved nutrition; these improvements take months rather than weeks to be reflected in death counts. What matters is that the child effect is still widening rather than fading, indicating that interventions are becoming more established rather than losing their impact.



Source: DRCH child health weekly returns

Figure 6: *Cumulative child deaths, 2026 against 2025.* The running total for 2026 stays below 2025 across the reporting period.

It is important to be honest about what the child figures currently indicate and what they do not yet reflect. A reduction of 14.4 per cent is real, and it is saving hundreds of children, but child mortality in this country remains far too high, and the absolute weekly numbers, well over a hundred deaths in a heavy week, are a sober reminder of how much ground there still is to cover. The trend is encouraging, but the problem is far from solved. The campaign's judgement is that the child side is where the largest remaining gains sit, precisely because progress has been slower, and that a determined focus on newborn care, emergency paediatric treatment, nutrition, and the high-burden facilities can bend the curve further in the second half and beyond.

Zero-dose immunisation coverage

The national target of 9,006 zero-dose children, meaning children who had never received a single vaccine, is now 79.0 per cent met, with 7,117 reached and vaccinated. This means that there are still 1,889 children who need to be located and vaccinated. These are not easy cases. They live in the settlements the routine system has always struggled to reach, and closing on them depends on microplanning, outreach, and the community structures the campaign has activated rather than on facility-based services alone. Section 3.5 details the methods used to achieve that reach and what remains.

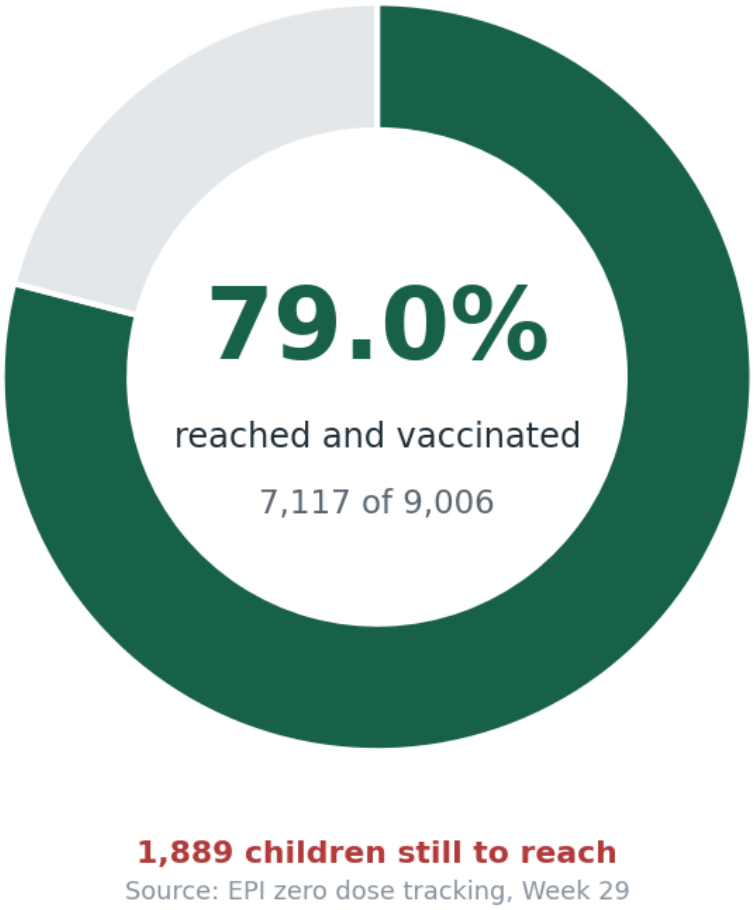


Figure 7: *Progress against the national zero-dose target at Week 29.*

Three districts, Falaba, Karene, and the Western Area Rural, have now vaccinated more zero-dose children than their original targets, by 464, 262, and 141, respectively. While this situation is advantageous, it also poses a data challenge that requires attention. Exceeding a target can mean strong outreach, but it can equally point to an underestimated denominator, population movement, children drawn in from neighbouring catchments, previously unmapped settlements, or double counting. The next step in these three districts is validation of the denominators and microplans.

Lives saved and the strength of the evidence

To answer the leadership's question, "How many lives has this saved?" the coordinating unit compared the actual outcomes to what the earlier level, trend, and seasonality would have produced. The difference to date is about 592 lives (61 mothers + 305 children directly, 226 children

indirectly), roughly 61 mothers and 291 children. These figures sit comfortably beside the year-on-year reductions in the weekly briefs, which is reassuring because two different methods point in the same direction. The maternal result is statistically significant at a probability of 0.022 and survives more demanding time-series models; the child result, at a probability of about 0.057, is on the borderline of conventional significance, which is precisely what a real but slower-building effect looks like at the halfway point. It is reported as borderline and growing rather than dressed up. The analytical approach, an interrupted time series with a modelled counterfactual checked against ARIMA, follows established methods for evaluating a population-level intervention of this kind [2], and the healthy years of life restored are expressed as disability-adjusted life years, a standard measure of the burden of disease and its aversion [12].

Reading the numbers with care

It is important to exercise caution when interpreting these figures. Weekly counts are noisy, and a single quiet or heavy week means little on its own, which is why the campaign works from trends and comparable periods rather than headlines. District counts are provisional until the weekly validation is complete. Facility mortality percentages must always be read alongside the number of admissions, since a high-volume referral hospital will show a higher percentage precisely because it receives the sickest patients from elsewhere. The estimate of lives saved is exactly that: an estimate based on a defensible comparison, provided because leadership needs a sense of scale, not because the exact figure should be considered a certainty. Reading the numbers this way is not hedging. It is what keeps the campaign's claims credible, which matters all the more as the country moves toward a point where it will want to say it has reached zero.

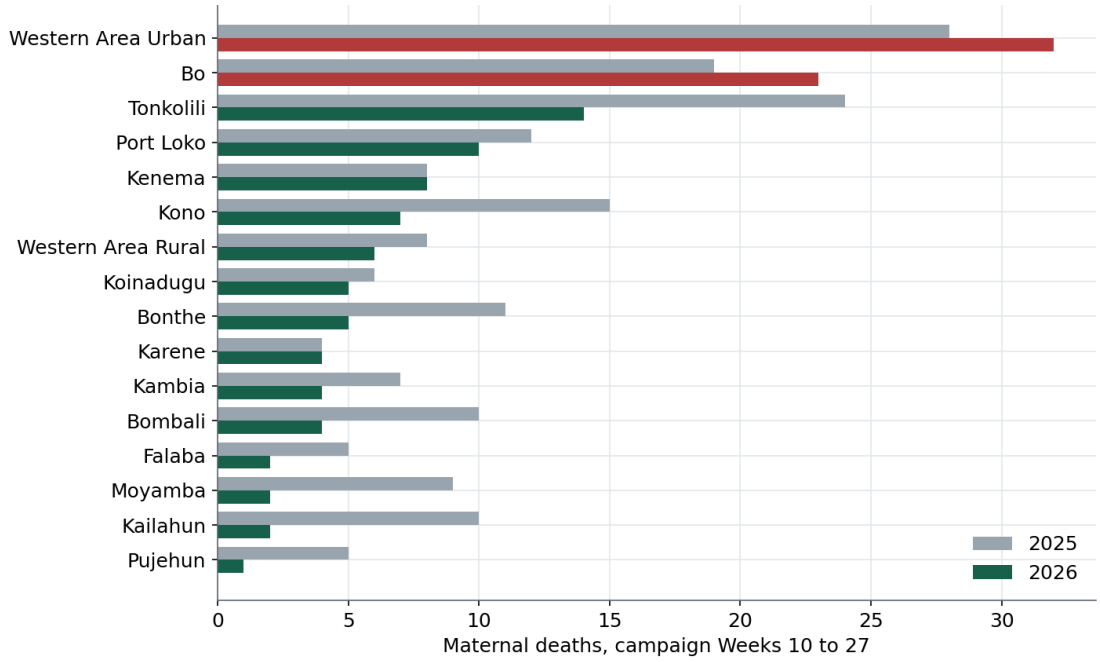
3.2 District performance and equity

The national picture across districts

National figures can hide as much as they reveal, so the campaign tracks every district against its performance last year. On the comparable campaign weeks, fourteen of the sixteen districts recorded fewer maternal deaths than in 2025, and several improved sharply. Tonkolili fell from 24 to 14, Kono from 15 to 7, Moyamba from 9 to 2, Pujehun from 5 to 1, and Kailahun from 10 to 2. Bombali, Bonthe, Kambia, Port Loko, and the Western Area Rural all recorded fewer deaths as well. Karene and Kenema recorded the same number of deaths as last year. Only two districts recorded higher numbers, and these are the two on which the campaign is now focused.



Figure 8: *How the sixteen districts are moving.*



Source: DRCH weekly maternal death line list, comparable window Weeks 10 to 27

Figure 9: *Maternal deaths by district, 2026 against 2025, comparable campaign weeks.*

The spread across districts is instructive in itself. It indicates that the national reduction is not the work of one or two large districts pulling the average down but a broad-based improvement that most of the country has shared. That breadth is relevant for the drive to zero because it means the campaign's methods work in very different settings, from the riverine south to the northern plateau, and are not dependent on the particular conditions of a single location. It also isolates the problem. When fourteen districts can improve and two cannot, the difficulty in those two is specific and local rather than a feature of the whole system, which is precisely why a targeted response to Bo and the Western Area Urban is the right one.

The two districts needing intensified support

Bo remains the single most serious maternal mortality concern in the country. On the cumulative comparison, it stands at about 35 maternal deaths against 27 in the same period last year, with deaths rising from 19 to 23 across the comparable campaign weeks. It is the only district where the campaign has had to mount a full ministry investigation, and it is being managed as an intensive support package rather than a routine district. Bo Government Hospital also carries a heavy child load, close to 300 deaths reported so far this year, and both sides of the district's work are under weekly national oversight.

The Western Area Urban has moved above its 2025 level, at about 55 cumulative maternal deaths against 45, with deaths rising from 28 to 32 across the campaign weeks. Princess Christian Maternity Hospital has featured repeatedly in the weekly reviews. The district also carries the country's heaviest paediatric burden through Ola During Children's Hospital and JMB Hospital. It needs focused attention on referrals, emergency response, and the quality of care inside its highest-volume maternity and paediatric units.

The Bo investigation and the Ministry response

When Bo emerged as the clearest outlier, the Ministry did not wait. A high-level investigation was mounted by senior MoH leadership into the rise in maternal deaths and the referral difficulties centred on Bo Regional Government Hospital, with senior clinical and programme leadership and the Bo District Health Management Team participating.

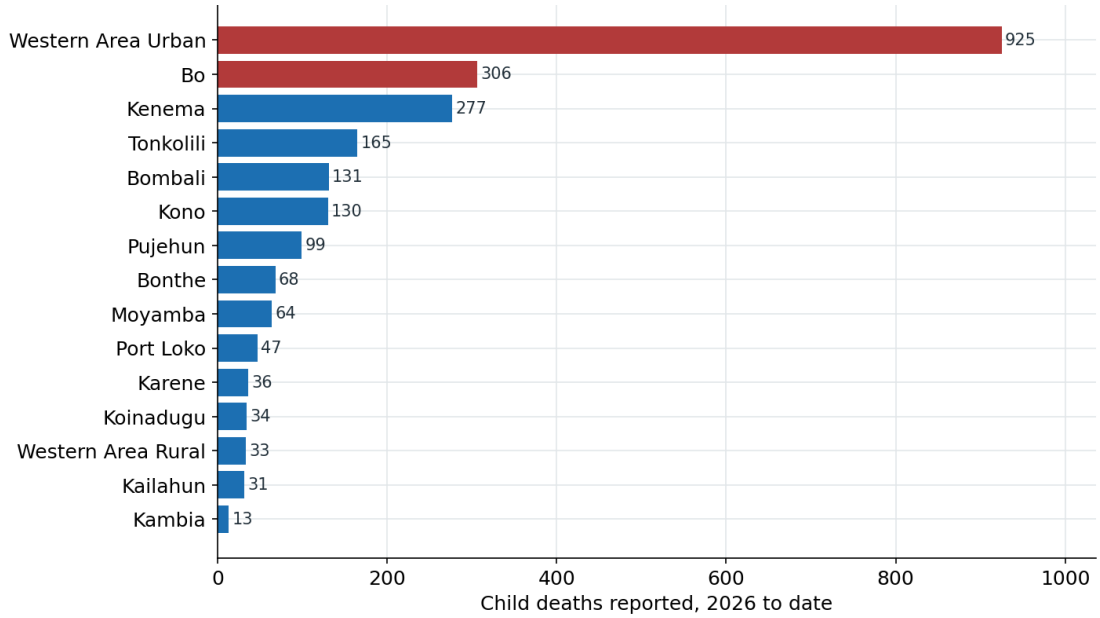
The system gaps were laid out without euphemism: weaknesses in leadership and accountability, poor clinical documentation, gaps in the death review process, referral delays, constrained blood supply, and shortages of the specialist staff a regional hospital cannot function without, including obstetricians, paediatricians, anaesthesiologists, and experienced midwives. Bed capacity in maternity and critical care was limited, essential medicines and equipment were short in places, and there were instances of staff not reporting to assigned duty stations. A review of the wider referral pathway, taking in Mathoir Community Health Centre, Hinistas Community Health Centre, and Moyamba Government Hospital, found blood transfusion services absent in some facilities meant to provide basic emergency obstetric care, non-functional laboratories and theatres in places, and shortages of community health officers with surgical training and of nurse anaesthetists.

Bo is now run as an intensive district support package. The response includes a full deep-dive review of every maternal death, completion of the outstanding reviews where documentation was missing, weekly maternal death action tracking with national oversight, drills for postpartum haemorrhage, eclampsia, and sepsis; work on blood availability and emergency donor mobilisation, tighter referral documentation between peripheral health units and the hospital, and direct attention to the leadership and accountability weaknesses the mission found. Weekly check-ins link the National Coordination Unit, the Bo District Health Management Team, and the Hospital Management Team so that agreed actions are tracked to completion rather than noted and forgotten. Bo serves as the most definitive test of the campaign's ability to transform a struggling district, and the country cannot achieve zero while Bo is heading in the wrong direction.

Part 5 explores a broader lesson in Bo that extends well beyond one district. A regional hospital can have buildings, a catchment, and a reputation and still fail mothers if its blood bank is empty at two in the morning, if the specialist on call does not come, if the record of what happened is never written, and if no one is held to account for the death. Bo is not short of effort; it is short of the systems that turn effort into survival, blood, staffing, documentation, accountability, and review, and those systems are exactly what the campaign exists to install. The Directorate intends to use what is being built in Bo as a template for turning around any struggling facility in the country.

What the strong performers teach

Several districts recorded no maternal deaths at all during July, among them Bombali, Bonthe, Falaba, Kailahun, Kambia, Moyamba, Port Loko, and Pujehun. Port Loko is worth singling out. In Week 28, it reported no maternal deaths and no deaths in its special care baby unit; held child mortality below 4 per cent across the district; and kept facility reporting completeness above 85 per cent for three weeks running. It has done this on thin margins, with a single monitoring and evaluation officer running the district situation room, which is itself a risk. The lesson the campaign is drawing from Port Loko and Kenema Government Hospital, which handled 207 child admissions with only two deaths in a single week, is to document what these performers are doing, protect the staff and commodities that make it possible, and pair a strong facility with a nearby struggling one for practical, peer-to-peer learning. Figure 10 displays child deaths by district.



Source: DRCH child health weekly returns aggregated by facility and district

Figure 10: *Child deaths by district, 2026 to date.*

3.3 Reproductive and maternal health and family planning

The maternal death reviews have given the campaign an unusually clear view of why women are dying, and the pattern is consistent. Postpartum haemorrhage remains the leading killer, followed by hypertensive disorders, sepsis, obstructed labour, and ruptured uterus, with severe anaemia running underneath many of these as a contributing cause. This mirrors the global pattern, in which haemorrhage and hypertensive disorders are the leading direct causes of maternal death [6]. Encouragingly, the cause-specific analysis shows that every one of the five leading groups of maternal causes fell during the campaign, with postpartum haemorrhage, the single biggest killer, down by roughly a third.

Cause	Pattern in the reviews	Common contributing factors
Postpartum haemorrhage	The leading cause, recurrent across districts	Uterine atony, retained placenta, delayed recognition of shock, delayed blood administration
Hypertensive disorders	Recurrent in facility and referral cases	Poor blood pressure monitoring, late presentation, delayed magnesium sulphate
Sepsis and puerperal sepsis	Frequent after delivery and surgery	Surgical site infection, delayed postnatal care, delayed source control
Obstructed labour, ruptured uterus	Recurrent in prolonged labour	Delayed recognition of poor progress, delayed referral, delayed caesarean
Severe anaemia	Direct or contributing to many deaths	Malaria, poor antenatal follow-up, delayed transfusion, nutrition gaps
Antepartum haemorrhage	Seen in multiple cases	Late presentation, bleeding at home, delayed emergency surgery, lack of blood

Table 1: *Leading causes of maternal death, review findings, and common contributing factors identified during the campaign (source: campaign maternal death reviews).*

The case notes repeatedly mention the three delays: deciding to seek care, reaching a facility, and receiving appropriate care once there [10], and it is worth being specific about each because the response differs.

The first delay, in deciding to seek care, shows up as women staying at home while bleeding, delaying after a fever or a wound discharge, refusing referral, attempting home delivery in a high-risk pregnancy, or not returning for postnatal review after a caesarean section. The answer to this delay lies in the community, in danger-sign recognition and in the trust that makes a family act quickly, which is why communication is treated as a clinical intervention (section 3.8).

The second delay, in reaching care, shows up as ambulance delays, transport barriers in riverine and challenging-to-reach areas, movement between facilities without a proper referral, and the use of commercial transport for critically ill patients. The answer lies in referral coordination, documentation and emergency transport (section 3.6).

The third delay, in receiving appropriate care, shows up as delayed recognition of shock, delayed senior clinical review, poor monitoring after an operation, blood not immediately available, weak adherence to emergency obstetric protocols, and delayed decisions for surgery. The first half of this campaign has clearly established that the third delay is the most urgent issue, as a significant number of women are dying even after they have received care. This is why the campaign has pushed emergency obstetric readiness so hard: uterotonics and a measured response for haemorrhage [13], magnesium sulphate within the first half-hour for eclampsia [14], early recognition of sepsis, blood on hand, and senior review before a woman deteriorates rather than after. These are precisely the emergency obstetric and newborn care signal functions that define whether a facility can save a mother in an emergency [15]; the expected functions by facility level are set out in

Antenatal care quality is the other reproductive health priority the reviews keep pointing to. Maternal deaths have occurred in women with few antenatal contacts, or with anaemia and hypertension that were inadequately managed during pregnancy. The response is to strengthen risk screening at antenatal care, in particular for anaemia, hypertension and infection, as recommended for a positive pregnancy experience [16], to hold high-risk pregnancies for facility delivery, and to insist on postnatal review after every caesarean section, since wound sepsis and secondary haemorrhage after surgery continue to feature in the deaths.

Family planning and post-abortion care have been brought squarely into the maternal survival agenda rather than treated as separate services. A six-day training course on comprehensive post-abortion care was run from 6th to 11th July with support from DKT International, bringing together twenty participants drawn equally from government and private facilities. The content covered the management of abortion-related complications, infection prevention and control, pain management, and family planning counselling and services, alongside the standards for respectful, non-judgemental care. This bears directly on the numbers, because unmet need for contraception and unsafe abortion sit behind a share of preventable maternal death and morbidity worldwide [6]. Reaching zero preventable maternal deaths is not possible without a family planning programme that lets women space and limit births safely, and that is now treated as part of the campaign rather than adjacent to it.



Photo 3: Clinical audit and chart assessment of abortion-related deaths

Postnatal care is the most neglected and dangerous part of the continuum. A large share of maternal deaths occurs in the days after delivery, from secondary haemorrhage, from sepsis, and from the complications of hypertensive disease that do not resolve the moment a baby is born. Globally, an estimated two-thirds of maternal deaths occur in the postpartum period, with the majority concentrated in the first 24 hours and first week after birth [6]. In sub-Saharan Africa, postpartum haemorrhage and puerperal sepsis together account for over 50 per cent of direct maternal deaths, many of which occur after the immediate delivery period [6]. Yet the maternal and child health handbook supervision found postnatal sections routinely left blank, and women who had undergone caesarean section were not reliably returning for review. The campaign has therefore made postnatal follow-up, and the return visit after a caesarean section in particular, an explicit expectation on facilities, because a mother who survives her delivery can still be lost in the week that follows if no one is watching for the danger signs.

3.4 Child health and newborn care

The child survival gains are real, but they are slower and more concentrated than the maternal ones. Malaria, pneumonia, sepsis, diarrhoea, severe anaemia, and malnutrition remain the recurring causes of death in children aged one month to five years, while birth asphyxia, prematurity, low birth weight, and neonatal sepsis are the leading causes of death in the first month of life; this distribution of causes is consistent across the region [7].

Age group	Leading causes of death
Newborns, 0 to 28 days	Birth asphyxia; prematurity and low birth weight; neonatal sepsis; congenital conditions; neonatal jaundice complications
Children, 1 to 59 months	Malaria; pneumonia; diarrhoea and dehydration; sepsis; severe anaemia; severe acute malnutrition; meningitis; sickle cell complications

Table 2: *Leading causes of neonatal and under-five mortality identified through child death reviews and facility surveillance (source: campaign child death reviews and facility return).*

The burden is heavily concentrated. Ola During Children's Hospital, the national referral point for the sickest children, carries by far the largest share of paediatric deaths, and a small number of high-volume facilities account for most of the rest (Figure 11). That concentration is both a difficulty and an opportunity, because a focused effort on a handful of facilities can move the national figure.

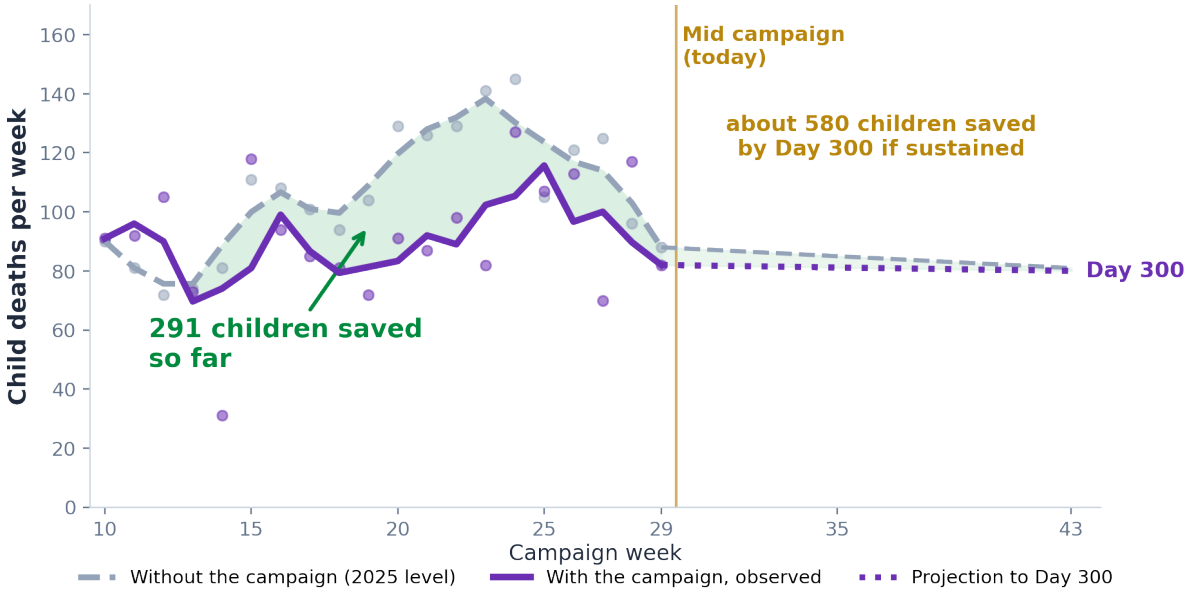


Figure 11: *Child deaths per week.*

Two facility-level responses have been prioritised. The first is at JMB Hospital in the Western Area, on early identification and treatment of neonatal sepsis and meningitis, prompt antibiotics, better infection prevention, and stronger neonatal monitoring and audit. The second is on severe malaria and newborn care in the districts, with attention to the uninterrupted supply of malaria diagnostics and artesunate, oxygen and pulse oximetry where pneumonia and respiratory distress are killing children [17], and the resuscitation and essential newborn care skills that decide whether a baby who is flat at birth survives.

The campaign is also pushing for child deaths to be reviewed with the same level of detail as maternal deaths. That means requiring lists of child deaths from every district and breaking deaths down by age group, facility, cause, referral status, time from admission to death, nutritional status, oxygen need, and treatment received. Deaths within 24 hours of admission are being tracked as a specific indicator, because they are the clearest signal of late presentation and of gaps in emergency triage. This is the analytical discipline that drove the maternal gains, now turned on the child side where the slower and larger returns still lie. It is here, more than anywhere, that the distance to zero remains greatest, and the plan reflects that.

Three practical fronts support the work of child health. Emergency triage, assessment and treatment (ETAT) at the front door of every hospital decides which sick child is seen first, and strengthening it is the single cheapest way to cut deaths within the first day of admission [18]. Newborn care and the special care baby units matter most where low birth weight and birth asphyxia dominate, and the upgrade of the resuscitation and emergency unit at Ola During is the clearest investment in this. Nutrition runs underneath a large share of child deaths, so the screening and management of severe acute malnutrition, and the availability of therapeutic foods [19], are treated as part of the survival package rather than a separate vertical programme.



Photo 4: *Emergency triage, assessment and treatment at a hospital*



Photo 5: *Newborn care in a special care baby unit*

3.5 Immunisation and the zero-dose agenda

Immunisation has been the quiet success of the campaign so far. Reaching 79.0 per cent of the zero-dose target means the health system has, for the first time, made contact with thousands of children it had never touched, the very children global immunisation strategy identifies as the hardest to reach and the highest priority [9]. The gain has come from mobilising the people that communities actually listen to. District social mobilisation coordinators, community health workers, paramount chiefs, religious leaders, women's groups and local councils have been used to find missed children rather than waiting for caregivers to present at a clinic.

The clearest example of how this is done comes from Bombali, where the district health management team, through its health education unit and its risk communication and community engagement pillar, convened stakeholder meetings across six low-performing chiefdoms and localities: Bombali Shebora Rural, Gbanti, Gbendembu, Kamaranka, Mara and Makeni City. Traditional and religious leaders, youth and women leaders, commercial motorbike riders and caregivers were brought into direct conversation about what vaccines prevent, the value of completing the schedule, and the rumours that hold uptake back. Stakeholders committed to support fixed and outreach sessions, to form local teams to address refusals directly, and to activate community byelaws requiring caregivers to comply with the schedule. Similar engagement has now been carried out across all districts.



Photo 6: Outreach vaccination team reaching zero-dose children in a hard-to-reach community

The task on the road to zero is twofold. The first is to reach the remaining 1,889 hard-to-reach children, who will be lost if outreach stops. The second is to convert first doses into completed schedules, tracing defaulters so that a child reached once does not become a dropout. Alongside this, the three districts that have exceeded their targets need their denominators and microplans validated, so that the coverage the country reports is coverage the country can stand behind. Zero zero-dose is not reached the day the counter passes 9,006. It is reached when every child, in every settlement, is found and fully immunised, and held there year after year.

Immunisation carries a lesson for the whole campaign, taken up in Part 5: it has moved fastest because it had a clear target, a named list of missing children, and a community machinery willing to go and find them. The zero-dose work is proof that when the health system decides to reach a specific, countable group of children, it can, and that is the confidence the country now takes into the more difficult parts of the goal.

3.6 Hospitals, clinical services, referral, blood and commodity security

This is the least visible part of the campaign and one of the most important. A weekly review can identify that a mother died for want of blood or a functioning theatre, but only investment of this kind fixes it. Four fronts are grouped here because they succeed or fail together: a woman survives a haemorrhage only if the referral reaches a hospital that has the blood, the theatre and the drugs ready when she arrives.

Hospitals and specialised clinical services

The hospital system has seen significant investment during this period, led by the Directorate of Hospitals and Ambulance Services, and much of it goes directly to the readiness that maternal and child survival depend on. On leadership and governance, the Directorate held its annual performance review and had Medical Superintendents sign performance contracts, instituted monthly general cleaning across all government hospitals to strengthen infection prevention and control, mapped hospital partners to align their support with real gaps, and established a patient complaint call line now posted in all government facilities so that problems reach management rather than fester in the wards. Supervision visits monitored the ongoing construction of the Moyamba and Pujehun hospitals, and on-the-spot checks were carried out across Western Area hospitals.

Capacity building has been substantial. Hospital Management Teams completed a leadership and management course delivered in collaboration with the University of Global Health Equity in Rwanda, combining in-person and online learning. The first cohort of a biomedical technology certificate course was completed with the University of Sierra Leone and Fourah Bay College, with technical support from UNICEF, Mercy Ships and Partners in Health, which begins to address the chronic problem of life saving equipment sitting idle for want of anyone trained to maintain it.

The additions to service delivery and infrastructure are substantial. Solar systems are being installed and monitored at twelve hospitals with support from the Foreign, Commonwealth and Development Office, which is relevant for everything from cold chain to theatre lighting. A 128-slice CT scanner has been installed and commissioned at Connaught Hospital and a 64-slice scanner at Kenema Government Hospital, extending diagnostic capacity that previously required referral or travel abroad. Staff buses have been provided to improve the mobility of health workers. A regional hospital assessment has been completed to guide the rehabilitation, equipping and staffing of emergency and high-dependency units. A National Burns Unit has been constructed and commissioned at Connaught Hospital. The emergency and resuscitation unit at Ola During Children’s Hospital, the facility that carries the country’s heaviest paediatric load, has been renovated and upgraded, which speaks directly to child survival rates. The Directorate believes these improvements are linked to the mortality figures; they are why the figures have changed and will help the country maintain its gains after the campaign.



Photo 7: *Solar installation commissioned at a supported hospital*



Photo 8: *Refurbished theatre*

Referral systems and emergency care

Referral is where many preventable deaths are decided, and the campaign has treated it as a system rather than a single service. The maternal reviews repeatedly show the second delay, in reaching care, driven by ambulance delays, transport barriers in riverine and hard-to-reach areas, movement between facilities without proper referral, and the use of commercial transport for critically ill patients. When a woman dies while being transported, as occurred in some cases reviewed during the campaign, it indicates that the referral chain has failed at multiple points.

The response has been to audit referrals in every death that involved a delayed referral, a refused referral or a death in transit; to improve coordination of referrals and strengthen the documentation that travels with a patient between a peripheral health unit and a hospital; and to tighten the coordination of ambulances through the National Emergency Medical Service. Emergency readiness at the receiving end is being addressed in parallel, because a fast referral into a facility that cannot transfuse, operate or resuscitate simply moves the place of death. The facility action plans shared in the weekly updates include specific hospitals, like Magburaka Government Hospital in Tonkolili, to improve how they respond to emergencies, get operating rooms ready, manage the time from decision to surgery, and improve communication and transport for referrals. Referral is also where the health system's geography bites hardest: a woman in a riverine chiefdom faces a longer, more dangerous journey than a woman near a regional hospital, and the campaign's equity commitment means those journeys cannot be treated as unavoidable. Until competent care is close to all emergencies, zero will remain unreachable in the hardest-to-serve areas.

Blood services

Blood availability sits behind a large share of maternal deaths, and it has been one of the campaign's most active fronts. The National Safe Blood Service, working with the northern regional blood transfusion centre at Makeni Regional Hospital and the Bombali District Health Management Team, convened a regional technical working group bringing together Bombali, Tonkolili, Koinadugu, Falaba and Karene to agree the operational roll-out of a decentralised hub-and-spokes model for safe blood. Under this model blood collected at a regional hub is screened, processed into components, stored under proper cold chain and dispatched to spoke hospitals on demand, so that a donation benefits several districts rather than staying where it was given.

The demand this has to meet is real. Makeni Regional Hospital alone requires at least fifteen units of blood a day, but this need is often unmet. The need for this model is growing as donor-supported

programs, like those from Concern Worldwide, are ending, because the country cannot let these changes lead to shortages of supplies at regional hubs and district hospitals. Two notable aspects emerge in the districts' responses. Bombali has taken the innovative step of convening all twelve of its paramount chiefs to agree on a monthly blood-donor drive per chiefdom, a locally owned way of guaranteeing a continuous supply throughout the year. Voluntary donation drives, such as the exercise run with the Sierra Leone Red Cross Society at Station Road in Makeni, are being used to build the stocks that keep blood banks functional during emergencies, surgery and maternal care. The reason blood matters so much to the Triple Zero goal is direct: postpartum haemorrhage, the leading cause of maternal death, is survivable when blood is on hand and fatal when it is not. A skilled midwife can see a woman who reaches a facility in time, but she may still die if there is no blood available.



Photo 9: *Voluntary blood donation drive, eastern regional blood transfusion service*

Medicines, vaccines and commodity security

A campaign against preventable death is only as effective as the medicines on the shelf when a woman is bleeding or a child is convulsing. During this period, the National Medical Supplies Agency delivered consignments of Free Health Care drugs and medical supplies to district medical stores, covering the first- and second-quarter allocations, directly complementing the Triple Zero goals. In Bombali, the delivery was received in the presence of the District Medical Officer, civil society, traditional leaders and other stakeholders, with commitments that the commodities would be managed transparently and used only for their intended purpose. The Free Health Care commodities are meant for the groups the policy protects, pregnant women, lactating mothers, children under five, persons with disabilities and Ebola survivors [8], and the emphasis from both the Agency and civil society was on getting them to the last mile rather than allowing them to sit in a central store.

Commodity security is not only about drugs. The supportive supervision of the maternal and child health handbook (section 3.7) found real supply-chain vulnerabilities in a printed commodity as basic as a home-based record, with stock-outs at district stores and low buffer stock at facilities. The lesson the campaign takes is that supply-chain discipline must reach every item the continuum of care depends on, from magnesium sulphate and oxytocin to blood and the handbook a mother carries between visits. When a facility reports a death from postpartum haemorrhage and the review finds there were no uterotonics on the shelf, that is a supply failure with a name attached to it, and it is escalated as such. The commodity work and the death-review work are two halves of the same effort, because a review that identifies a missing drug is only useful if the drug is on the shelf the next time it is needed.

3.7 Primary health care, district teams and the workforce

Primary health care and the maternal and child health handbook

Primary care is where most contacts with mothers and children happen, and the maternal and child health handbook is the thread meant to hold the continuum together, from antenatal care through delivery, postnatal care, immunisation, growth monitoring, and nutrition. A supportive supervision exercise was carried out by staff of DRCH from 7th to 12th June across Moyamba, Pujehun and Bo with technical and financial support from the Japan International Cooperation Agency (JICA), reaching district health management teams, community health centres, community health posts, maternal and child health posts, and district and private hospitals.

The findings deserve the Minister's attention because they paint a picture of a tool the country is relying on. Community acceptance is high, since the handbook provides a mother with a single, free record of her own and her child's care, with pictures that support health education. Utilisation during antenatal care, immunisation and nutrition counselling is generally satisfactory; the problem is documentation quality and supply. Sections on client identification, antenatal visits, childhood immunisation and growth charts are well kept, but birth-preparedness plans, delivery outcomes, postnatal-care tracking, tetanus vaccination, nutrition assessment, counselling summaries, referrals and family planning are frequently left blank. In several sites, the handbook was bypassed entirely in the maternity unit during active labour, which is precisely where good records matter most. Heavy client workloads, a complete lack of orientation for newly deployed staff, and non-use of the accompanying user guide were the drivers.

The district picture was specific. Moyamba showed high use during antenatal and immunisation sessions and steady availability, but major lapses in postnatal and nutrition documentation and staff still need training. Pujehun showed exceptional political goodwill, with the District Council Chairman and members formally committing to local awareness campaigns and to financing supplemental printing of the handbook, alongside inconsistent documentation of delivery outcomes and referrals. Bo showed strong community turnout but weak documentation under high volume, frequent discrepancies between facility registers and handbooks. The team provided on-the-job mentoring, live demonstrations of growth-chart plotting, and rapid debriefings with facilities, district teams and councils. The recommendations that followed – an audit of the missing handbooks in Bo, an uninterrupted national supply, mandatory orientation for newly deployed staff, periodic data-quality assessments and formal oversight of private facilities using public commodities – are being taken forward.

District health management teams and taskforces

The most important structural change in the first 150 days is that districts are no longer only receiving instructions from the centre. They are being asked to interpret their own weekly data, explain their bottlenecks and act on them. Every district has an active taskforce, and these are meeting and functioning rather than existing on paper. In Bombali, the taskforce met in the emergency operations centre conference hall in mid-June, chaired by the risk communication pillar lead, reviewing action points and taking updates on maternal and perinatal death surveillance, child health, zero-dose reporting and the special care baby unit. In Koinadugu, the taskforce met in the district's situation room, with the district medical officer and the paramount chief representative reviewing performance and agreeing on how to sustain it.

The district taskforces also carry the campaign's most valuable political asset: local ownership. When a paramount chief sits on a taskforce, when a district council commits its resources, as Pujehun has done for the handbook, and when chiefdom leaders agree to byelaws on vaccination, the campaign stops being a national instruction and becomes a local commitment. That shift is what makes the gains durable. A district that takes ownership of its maternal deaths will keep working on them, regardless of a report in Freetown. Deepening that ownership, district by district, is central to reaching a zero that holds.



Photo 10: *Kambia District taskforce meeting with the paramount chief and district council present*

Human resources for health

Staff shortages are the constraint that shows up behind almost every other one, from an unstaffed theatre to a situation room run by a single officer. Two lines of work have advanced during this period. The Health Service Commission has been conducting nurse recruitment interviews across regional centres, organised so that candidates from Bombali, Port Loko, Kambia, Karene, Tonkolili, Koinadugu and Falaba were interviewed in Makeni on 13 and 14 July, followed by Bo on 15 July, Kenema on 16 July, the Western Area Urban on 21 July and the Western Area Rural on 23 July.

Health management teams in the districts were engaged ahead of the interviews to confirm their readiness to facilitate the process in line with the national recruitment timetable.

Alongside recruitment, the campaign period has invested in the skills of staff already in post, through the hospital leadership and management course delivered with the University of Global Health Equity and the first cohort of biomedical technicians trained with local universities and partners. Mentorship has been targeted where it changes outcomes, including clinical mentorship in the management of sick children at Bo Government Hospital by a consultant paediatrician, one-on-one support for district monitoring and evaluation officers to strengthen data quality and the use of routine information for decisions. Deployment discipline remains a live issue because Bo found staff not reporting to assigned duty stations, and it is being handled as an accountability matter rather than a training issue. Reaching zero will not be possible without enough skilled hands in the right places, and workforce is therefore treated as a survival issue, not an administrative one.

3.8 Communications and community engagement

The campaign has worked from the position that many maternal and child deaths begin at home, with a delayed decision to seek care, the first of the three delays [10], and that communication is therefore a clinical intervention rather than a supporting activity. The partnership with the Ministry of Information and Civic Education has been central to taking the message beyond the health sector. The Ministry has facilitated focus group discussions with district health teams and facility staff to strengthen the joint effort toward the three goals, and community stakeholder meetings have now been conducted across all districts to advance the communication agenda in chiefdoms and communities.

The campaign has also used national platforms to reach people at scale. At the Presidential Town Hall meeting held at the Fatima Campus of the University of Makeni under the theme Year of Action, a dedicated health exhibition brought together the Bombali District Health Management Team, Makeni Regional Hospital, the National Emergency Medical Service and the national mobile clinic operating as a hospital on wheels. The booth raised awareness of epidemic-prone diseases, including Ebola, cholera, and measles; promoted maternal, child, and reproductive health and nutrition; demonstrated infection prevention, including hand-washing at every entrance and exit; kept ambulances on standby; and provided free diagnosis and treatment on the spot. It amplified the 117 toll-free line and was supported at senior level by the Deputy Minister of Health I, the Chief Medical Officer, and the Executive Director of the National Public Health Agency.



Photo 11: *Presidential Town Hall, Fatima Campus, University of Makeni*



Photo 12: *Community engagement session with traditional and religious leaders*

The messages themselves are kept simple and consistent, because they have to survive translation into every community in the country: bleeding in pregnancy or after delivery is an emergency; convulsions in pregnancy need immediate care; fever after delivery or surgery must be treated at once; a sick child with rapid breathing or convulsions needs urgent care; and every child should complete vaccination. Community structures, paramount chiefs, religious leaders, women's groups, youth and commercial motorbike riders carry them, and in the immunisation work communities have gone as far as agreeing byelaws to hold caregivers to the vaccination schedule. The campaign has been deliberate about who carries the message: a danger sign explained by a nurse reaches the woman in front of her, but the same message carried by a paramount chief, an imam, a pastor, a market women's leader or a respected motorbike rider reaches a whole community and carries the weight of local authority. Building and protecting those relationships is slow, unglamorous work, and it is among the most important things the campaign is doing for the long run.

3.9 Data, surveillance and death review

None of the results in this report would exist without the weekly data discipline that now underpins the campaign. Every maternal death is meant to trigger a review within seven days, with cause, delay, referral status, place of death and an action plan recorded, the country's application of maternal and perinatal death surveillance and response [11]. The maternal mortality line list has been rebuilt to carry additional validated indicators and is now held on a secure cloud-based platform to cut reporting errors and protect the record. Weekly situation briefs give leadership a consistent picture of deaths, districts, causes, immunisation progress and the actions owed back.



Photo 13: *Maternal death review meeting under way at a district hospital*

The campaign has also been willing to chase the gaps in its data. When a maternal death review at Princess Christian Maternity Hospital was held up because the patient's case file had gone missing, a Directorate team visited and tasked the facility with reconstructing the record so the

review could be completed. At Magburaka Government Hospital, reviews of all maternal deaths were completed and mandatory senior-clinician post-operative reviews introduced to strengthen monitoring. The honest weaknesses that remain are known: documentation is still incomplete in places, child death causes are under-recorded compared with maternal ones, and the numbers reported for zero-dose in the three over-performing districts need validation. Protecting the credibility of the data, through routine data-quality assessments and a gradual move toward rates rather than raw counts, is part of the drive to zero, because a claim to have reached zero has to be a claim the data can carry.

The wider point is that the campaign has changed the standing of data in the health system. A death is no longer only a number in a weekly total. It is a case with a name, a cause, a delay, a place and a set of actions that someone is accountable for completing. That shift, from counting to reviewing to acting, is the most durable thing the campaign has built, because it is a way of working rather than a one-time result.

3.10 Research, partnerships and financing

Research and the evidence base

The campaign has begun to generate evidence rather than only activity, which is unusual for a programme of this kind and puts the country in a position to defend and publish its results. Implementation research is being launched on family planning and post-abortion care, which will test in real district conditions how best to expand services that directly bear on preventable maternal deaths. Underpinning the analysis is a body of work carried out by the coordinating unit: rather than resting on year-on-year comparisons alone, the team has used interrupted time series and ARIMA models to test whether the fall in deaths is real and how much can be attributed to the campaign [2] and has built an explicit comparison against what would otherwise have happened to estimate deaths averted. The next step the analysts recommend is to extend the baseline and adopt formal controls, which will make the evidence for reaching and holding zero stronger still.

Partnerships behind the campaign

The campaign is a Government of Sierra Leone effort, led by the Ministry of Health, but it has drawn support from a range of partners whose contributions are recorded here so that credit is placed where it is due and coordination stays honest. The Japan International Cooperation Agency supported the supportive supervision of the maternal and child health handbook across Moyamba, Pujehun and Bo. UNICEF, Mercy Ships and Partners in Health supported the biomedical technology training with the University of Sierra Leone and Fourah Bay College. WHO supported the task force inception meetings and outreach in five high-volume facilities in all districts. The Foreign, Commonwealth and Development Office supported the installation of solar systems across twelve hospitals. The University of Global Health Equity in Rwanda delivered the hospital leadership and management course. DKT supported the training on comprehensive post-abortion care. The Sierra Leone Red Cross Society has supported voluntary blood donation. Support previously channelled through Concern Worldwide is winding down, which is precisely why the decentralised blood model and locally owned donor drives now matter so much.

Partner support has been mapped against real gaps rather than accepted piecemeal, and the hospital partner-mapping exercise carried out by the Directorate of Hospitals and Ambulance Services is the model for how this should work across the campaign, so that help lands where the bottleneck is and not where it is easiest to give. Several of the schemes that have supported

maternal and child survival in recent years are winding down, and the campaign has treated this not as a crisis to be lamented but as a reason to build systems the country can run itself, the decentralised blood service, the training of biomedical technicians who can maintain and repair the country's own equipment, and the investment in situation rooms and data systems that belong to the districts. Reaching zero and holding it cannot depend on any single partner.

Financing and stewardship

The most important point about the cost of the campaign is that the delivery system has already been built and largely paid for. The national coordinating unit, the weekly reviews and the district taskforces are standing structures, and the marginal cost of keeping them running is low relative to what they deliver. The investments recorded in this report, in blood systems, medicines, diagnostics, hospital infrastructure and staff, are assets that will keep working for women and children well beyond the campaign window.

Stewardship has been treated as part of the work rather than an afterthought. Free Health Care commodities have been received publicly, with civil society and traditional leaders present, and with explicit commitments that they will be used only for their intended purpose. The patient complaint call line, the performance contracts signed by Medical Superintendents and the routine data-quality checks are all mechanisms to ensure that what is spent reaches the bedside. The campaign incurs costs and requires sustained funding for blood systems, oxygen, specialist staff, and functioning theatres, with previous sections highlighting where shortfalls result in lost lives. The point is one of sequencing. The country has already made the larger investment, in building a delivery system that works, and the task now is to fund the specific gaps that stand between the current position and zero, to protect that spending from leakage, and to show, through the data, that every leone spent is reaching the bedside. The Directorate assesses that reaching zero depends not only on funding but also on execution, accountability, and finishing what's begun, which are the focus of the second half.

Part 4. Bottlenecks

Several risks stand between the country and zero. They are set out plainly here, grouped by type, so they can be managed rather than discovered late. A campaign that conceals its risks often succumbs to them, while one that identifies them can strategise accordingly. Each of the bottlenecks below is already being actively managed, and each maps directly to a priority in Part 6.

Clinical quality and the third delay. The frontier of progress has moved inside the facility. A significant share of deaths now happens after a mother or child has already reached care, which makes facility readiness and clinical discipline, blood ready, magnesium sulphate and uterotonics on hand, senior review before deterioration, functioning theatres, emergency triage and treatment for children, the binding clinical constraint for the next stretch. This is concentrated in two places, and a handful of facilities: Bo and the Western Area Urban carry the maternal deaths that hold back the national figure, and a small number of high-volume hospitals carry most of the paediatric deaths. Turning them around is slow, technical work, and the country cannot reach zero while they move the wrong way. Related to this issue is the risk of rebound: the maternal reduction has already eased from its early peak, and if weekly clinical pressure is removed, mortality could drift back toward the earlier baseline. The gain is real but not yet locked in.

Supply security. Facilities continue to report shortfalls in blood, oxygen and essential medicines, any one of which can turn a survivable emergency into a death. This risk is rising rather than falling, because several donor-supported schemes are winding down. Unless the decentralised blood model and locally owned donor drive hold, and unless the Free Health Care pipeline stays full from the National Medical Supplies Agency through to the peripheral health unit, the exits of external support will show up as stock-outs at exactly the moments that matter most.

Workforce fragility. Some of the best results in this report rest on very few people: a single monitoring and evaluation officer running a district situation room, a lone specialist covering a regional hospital. That is a fragile base for national gain, and it means a single transfer, illness, or resignation can undo a district's progress. Underneath sits the chronic shortage of the specialist staff a regional hospital cannot function without obstetricians, paediatricians, anaesthetists, nurse anaesthetists and experienced midwives, and, as Bo showed, a deployment-discipline problem in which posted staff do not always reach or remain at their stations.

Data credibility. The campaign's claims are only as strong as the data behind them. If the clinical documentation is incomplete, if the causes of child deaths are not recorded as thoroughly as those of maternal deaths, and if the zero-dose denominators in the three high-performing districts are not verified, these issues could be used to challenge the results. As the country moves toward a point where it will want to state that it has reached zero, the credibility of the record becomes a frontline issue, not a back-office one.

Sustainability. The hardest 1,889 zero-dose children will be reached only if the outreach machinery keeps running; they will be lost the moment it stops. More broadly, the whole gain depends on the campaign's habits, the weekly cycle, the seven-day death review, the line lists, the community structures, becoming the ordinary way the health system runs, rather than a burst of effort that fades when the campaign banner comes down. The central sustainability risk is that the machinery is treated as temporary.

These are not reasons for pessimism. They are a map of where attention must go. The Directorate would rather bring these difficulties to attention now, while there is time to act, than explain them after the fact.

Part 5. Lessons Learnt

The first 150 days have taught the campaign as much about reaching zero as about how far away it is. The following lessons are based on what actually influenced the numbers and what turned out to be more challenging than anticipated. They are designed to transfer to the second half of this campaign, other programmes, and the health system, which must maintain the goal after 300 days. They fall into three groups: operational, data, and system-level.

Operational lessons

A short, weekly cycle changes behaviour more than any single input. The clearest operational finding is that shortening the distance between a problem appearing and the system responding is itself an intervention. A weekly rhythm catches a deteriorating facility, a stock-out or a cluster of deaths while there is still time to act, where a monthly or quarterly rhythm lets a problem run. This phase is also the cheapest part of the campaign to sustain because it uses structures that already exist. The transferable lesson is that cadence is a design choice with a mortality effect, not an administrative detail.

Naming districts and facilities is effective because it reveals issues that averages can obscure. The campaign's habit of tracking every district against its own past, and naming the specific hospitals in the weekly action plans, is what isolated the problem to Bo, the Western Area Urban and a handful of high-burden facilities. A national average would have shown steady improvement and concealed exactly the places that need the most help. Naming is uncomfortable, but it is what directs effort to where deaths actually occur.

A countable target with a named list mobilises a system. Immunisation moved fastest of the three zeros, and the reason is instructive: it had a finite, countable target, a named list of missing children, and a community machinery willing to go and find them. The challenges on the maternal and child health sides are more difficult to address because their equivalent, a named list of the facilities and delays that contribute to the remaining deaths, is only now being assembled with the same level of clarity. The lesson the campaign is applying in its second half is to make the maternal and child work as concrete and countable as the zero-dose work already is.

Local ownership is what makes a gain durable. Where a paramount chief sits on a taskforce, a district council funds handbook printing, or chiefdoms pass bye-laws on vaccination, the campaign stops being a national instruction and becomes a local commitment. Gains that a district feels as its own survive the end of a reporting requirement; gains imposed from the centre tend not to.

Data lessons

Turning a death from a number into a reviewed case is the most durable thing built. The shift from counting deaths to reviewing them – cause, delay, place, and an action someone is accountable for – is what produced the maternal gains, and it is a way of working rather than a one-time result. The same discipline is now being turned on the child side, where causes have historically been under-recorded and where the largest remaining returns lie. The lesson is that

death review is not paperwork; it is the mechanism that converts a death into a prevented one next time.

Honesty about uncertainty protects credibility. The campaign has incurred no cost and has gained significant protection by reporting the child-mortality result as borderline, the lives-saved figure as an estimate, and the over-target zero-dose districts as a denominator problem rather than a triumph. As the country nears zero, a record that distinguishes the certain from the provisional is worth more than an oversold one. The transferable lesson is that credibility is built in advance, by never claiming more than the data carry.

Reliable data also requires a supply chain. The campaign learned, from the handbook supervision and from missing case files, that documentation fails for the same mundane reasons drugs do: no orientation for new staff, no buffer stock, no one accountable for the record. Treating data quality as a logistics problem, with the same discipline applied to commodities, is the practical lesson.

System-level lessons

Effort is not the same as a system, and Bo is the clearest teacher. The deepest lesson of the first half is the one Bo made unavoidable: a hospital can have buildings, a catchment, a reputation and hard-working staff, and still fail mothers if the blood bank is empty at two in the morning, the specialist on call does not come, the record is never written, and no one is held to account. Bo is not short of effort; it is short of the systems that turn effort into survival. What is being built there – blood, staffing, documentation, accountability and review – is therefore a template for turning around any struggling facility, and the campaign intends to use it that way.

The third delay is the hard frontier, and it was more challenging than expected. At the outset, it was reasonable to expect that reaching more women and children in time would be the main task. What the reviews established instead is that a large share of deaths occur after care is reached, which moves the hardest work inside the facility into clinical quality and readiness. The process is slower and more technical than community mobilisation. The system-level lesson is that once access improves, quality becomes the binding constraint and must be resourced accordingly.

Building for the exit of partners is a system strategy, not a contingency. With several donor schemes winding down, the campaign's most durable choices have been the ones that replace external support with something the country owns: the decentralised blood service and chiefdom donor drives in place of an externally funded supply, biomedical technicians who can maintain the country's own equipment, situation rooms and data systems that belong to the districts. The lesson is to treat partner exit as a prompt to build local systems rather than as a gap to lament.

Thin staffing is a system risk, not a local one. That some of the best results rest on one or two people is not a district curiosity; it is a national vulnerability, because it means excellent performance is one transfer away from collapse. The lesson is that resilience – enough trained people that no result depends on a single person – has to be built deliberately, and that protecting and replicating what strong performers do is as important as fixing what weak ones lack.

Part 6. Way Forward and Recommendations

6.1 The drive to zero

The Honourable Minister has set the target as zero, not as a better number, and the Directorate has taken that literally. Reaching zero preventable deaths is a different task from reducing fatalities, and it changes what the campaign has to do next. A reduction can be achieved by lifting the average; zero can only be achieved by closing every gap through which a mother or a child still falls, one facility, one referral, one review, one settlement at a time.

What that means in practice is now well understood, because the first 150 days have shown exactly where the remaining deaths are coming from: a small number of facilities carrying most of the burden, the third delay inside those facilities, two districts moving against the trend, the hardest-to-reach unvaccinated children, and the recurring failures of blood, referral, and documentation that turn a survivable emergency into a death. Zero is reached by fixing these specific things, not by exhortation. It also means building the campaign's habits into the ordinary running of the health system, so that survival does not depend on a campaign banner. The weekly death review, the seven-day rule, the district situation room, the maternal and child death line lists, the community structures that find missed children and carry danger-sign messages, the decentralised blood service, and the readiness of emergency obstetric and newborn care are the permanent machinery of a country that has reached zero and intends to stay there. The campaign period is being used to install that machinery and to prove it works.

It should be said plainly that every country reaches zero preventable death through sustained effort. It is reached by deciding that every preventable death is unacceptable, by building the systems that make prevention reliable, and by refusing to look away from the places where the systems still fail. Sierra Leone has carried a heavy burden of maternal and child death for a long time [3][4], and the honest position is that zero is a journey rather than a destination that will be reached in 300 days. What the campaign can do, and what it is doing, is put the country firmly on that road, prove that large reductions are achievable here and not only in wealthier settings, and leave behind a health system that treats the goal as its own.

6.2 Priorities and the plan to zero

The problems have been identified; what remains is the disciplined execution of the plan to address them. The plan focuses on the specific sources of the remaining deaths and is deliberately short because a plan that tries to do everything usually achieves little. Each priority below has an owner in the coordinating unit, a place in the weekly cycle, and a way of knowing whether it has been done.

1. **Turn around the two districts.** Concentrate on intensified support, referral audits, blood availability, specialist staffing and accountability on Bo and the Western Area Urban until they move with the rest of the country.
2. **Address the high-burden facilities.** Target the handful of hospitals that carry most of the maternal and child deaths: Ola During, Princess Christian Maternity Hospital, and the regional and district hospitals named in the weekly briefs, with readiness, mentorship and audit.

3. **Close the third delay.** Make emergency obstetric and newborn care reliable inside facilities, with blood, magnesium sulphate, uterotonics, oxygen, antibiotics, senior review and drills, so that reaching care means surviving.
4. **Finish the zero-dose work.** Reach the final 1,889 children through microplanning and outreach, convert first doses into completed schedules, and validate the districts that have exceeded target.
5. **Elevate child survival.** Give newborn and emergency paediatric care, nutrition, malaria control and referral the same rigour applied to maternal death, since these areas are where the greatest distance to zero remains.
6. **Lock in the maternal gains.** Sustain weekly reviews and maternal death surveillance so the early reduction is defended against rebound.
7. **Institutionalise the machinery.** Embed the weekly cycle, the death reviews, the line lists and the community structures into the ordinary running of districts and facilities, so the gains outlast the campaign.
8. **Protect the credibility of the data.** Run routine data-quality assessments and move toward rates, so that every claim, including a future claim of zero, withstands scrutiny.

6.3 Recommendations

The following are put forward as recommendations to the leadership of the MoH for decision and direction. Each is stated as an action, with the office that would carry it and the evidence by which its completion can be judged, so that progress can be tracked in the same weekly cycle that has served the campaign so far (Table 3).

#	Recommendation	Implied owner	How completion is verified
1	Hold the goal at zero and direct that the second half be judged on execution against the specific gaps identified, not on averages.	Minister's office; 300 Days Coordinating Unit	Weekly brief reports against named gaps, not headline averages; standing direction issued to districts
2	Direct resources to where the deaths are – Bo, the Western Area Urban, the high-burden facilities, child survival and the final zero-dose children – rather than spreading effort evenly.	Coordinating Unit; Directorates of RCH and Hospitals	Intensive-support packages active in both districts; facility action plans tracked to closure; resource allocation matches the burden map
3	Back the decentralised blood service and locally owned donor mobilisation and guard the Free Health Care supply chain against the wind-down of donor schemes.	National Safe Blood Service; NMSA; DHMTs	Hub-and-spokes model operational across the northern region; chiefdom donor drives running monthly; zero reported blood/uterotonic stock-outs at named hubs
4	Close the staffing gaps that cost lives and hold deployment discipline as an accountability matter.	Health Service Commission; DHRH; DHMTs	Specialist posts filled at named regional hospitals; nurse recruitment completed on the national timetable; documented action on staff not at duty stations

#	Recommendation	Implied owner	How completion is verified
5	Institutionalise the campaign's machinery, the weekly review cycle, the seven-day death review, the line lists and the community structures, in the permanent running of the health system.	Directorate of RCH; DHMTs	Weekly cycle and seven-day review continuing under routine budgets; structures reflected in district plans, not campaign instructions
6	Hold the line on accountability and data: require evidence of completed action from districts and institute routine data-quality assessments.	Coordinating Unit; district M&E officers; DPPI	Share of reviews completed within seven days and actions closed on time rising; periodic data-quality assessments on the record
7	Support the campaign to complete and publish its research, protecting the country's claims and strengthening the case for support.	Directorate of RCH; research partners	Manuscript through peer review; implementation research on family planning and post-abortion care launched with extended baseline and controls

Table 3: *Recommendations to the Ministry of Health Leadership for Decision and Direction – Owners, Actions, and Verification Criteria*

None of these asks require a new campaign or a new structure. They request that the existing machinery continue operating, focus on the specific gaps causing deaths, and remain shielded from distractions that typically derail successful initiatives. The Directorate is ready to act in the direction of the MoH on each of them, and to account for progress against them in the weekly cycle.

6.4 Conclusion

One hundred and fifty days into the 300 Days of Activism for Triple Zero, the campaign has achieved its initial objectives. The campaign has transformed into a delivery system, shifted the country from merely counting deaths to actively reviewing and preventing them, and achieved a significant and measurable reduction in maternal and child deaths that is highly unlikely to be due to chance. It has reached thousands of children the system had never touched, invested in the hospitals, blood, medicines, staff and data that survival depends on, and been honest about the two districts and the handful of facilities where the work is not yet done.

The women and children of this country do not experience an average. They experience a particular facility on a particular night, with or without blood, with or without a skilled hand, and with or without the decision to move in time. The first half of this campaign has been about making that night safer, one district and one review at a time. Zero is not a slogan for us. It is the only acceptable number of preventable deaths, and the plan set out here is how the Directorate intends to reach it and to hold it, during these 300 days and in every year that follows. The work of the next 150, and of the years beyond them, is to finish what has been started, to reach the mothers and children still being lost, and to make survival ordinary.

Appendix

The annexes hold the underlying evidence for the report and are referenced in the relevant sections. All internal counts are provisional until weekly validation is complete.

Annex A. National Summary Indicators at Day 150

Indicator	2026	2025	Change
Maternal deaths, campaign period (Wks 10 to 29)	141	202	30.2% lower
Child deaths, campaign period (Wks 10 to 29)	1,816	2,121	14.4% lower
Zero dose children reached (of 9,006)	7,117	—	79.0% reached
Zero dose children still to reach	1,889	—	21.0% remaining
Estimated lives saved to date	352	—	61 mothers, 291 children

Campaign period figures compare the same reporting weeks in 2026 and 2025. District counts are provisional and subject to weekly validation.

Annex B. Maternal Deaths by District, Campaign Weeks 10 to 29

District	2025	2026	Direction
Bo	23	24	Higher
Bombali	12	4	Lower
Bonthe	11	5	Lower
Falaba	5	2	Lower
Kailahun	12	2	Lower
Kambia	9	4	Lower
Karene	6	5	Lower
Kenema	10	8	Lower
Koinadugu	7	5	Lower
Kono	16	9	Lower
Moyamba	9	2	Lower

District	2025	2026	Direction
Port Loko	14	10	Lower
Pujehun	5	2	Lower
Tonkolili	24	15	Lower
Western Area Rural	9	6	Lower
Western Area Urban	30	38	Higher
National	**202**	**141**	**Lower**

On the cumulative watch list, the Western Area Urban stands at about 55 against 45, and Bo at about 35 against 27.

Annex C. Weekly National Maternal and Child Deaths, Weeks 1 to 29

Week	Maternal 2025	Maternal 2026	Child 2025	Child 2026
W1	6	3	71	41
W2	4	4	76	83
W3	4	12	77	83
W4	14	6	62	101
W5	9	5	73	74
W6	9	9	58	98
W7	9	12	90	82
W8	9	8	103	101
W9	8	7	66	79
W10	12	5	90	91
W11	9	6	81	92
W12	7	12	72	105
W13	20	6	74	73
W14	8	4	81	31
W15	10	7	111	118
W16	15	6	108	94

Week	Maternal 2025	Maternal 2026	Child 2025	Child 2026
W17	7	3	101	85
W18	6	9	94	81
W19	9	12	104	72
W20	11	9	129	91
W21	9	6	126	87
W22	8	8	129	98
W23	9	6	141	82
W24	10	10	145	127
W25	9	9	105	107
W26	11	7	121	113
W27	11	4	125	70
W28	9	8	96	117
W29	12	4	88	82

Campaign weeks run from Week 10.

Annex D. Child Deaths by Facility, 2026 to Date

Cumulative child deaths reported by facility for 2026 through the latest validated week, with the same period in 2025 for comparison. Totals are provisional.

Facility	District	2025 to date	2026 to date
Ola During Children's Hospital	Western Area Urban	654	694
Bo Government Hospital	Bo	222	298
Kenema Maternity Hospital	Kenema	0	221
Magburaka Government Hospital	Tonkolili	205	135
Makeni Regional Hospital	Bombali	145	131
Koidu Government Hospital	Kono	92	130
JMB Hospital	Western Area Urban	77	112
Pujehun Government Hospital	Pujehun	151	99
Rokupa Government Hospital	Western Area Urban	117	67
Moyamba Government Hospital	Moyamba	84	64

Facility	District	2025 to date	2026 to date
Mattru Hospital (UBC)	Bonthe	113	51
Kingharman Road Hospital	Western Area Urban	51	51
Kenema Government Hospital	Kenema	89	49
Kamakwie Wesleyan Hospital	Karene	0	36
Kabala Government Hospital	Koinadugu	73	34
St John of God Hospital	Port Loko	56	33
Sierra Leone China Teaching Hospital	Western Area Rural	15	33
Kailahun Government Hospital	Kailahun	76	28
Masanga Hospital	Tonkolili	35	25
Bonthe Government Hospital	Bonthe	22	17
Kambia Government Hospital	Kambia	47	13
Port Loko Government Hospital	Port Loko	61	11
Serabu Mission Hospital	Bo	28	8
Panguma Hospital	Kenema	10	7
Lion Heart Hospital	Tonkolili	18	5
Nixon Memorial Hospital	Kailahun	20	3
Lungi Government Hospital	Port Loko	13	3
Lumley Government Hospital	Western Area Urban	11	1
National total		**2,485**	**2,359**

Annex E. Weekly Monitoring Indicators

The short set of indicators is reviewed by leadership each week. Keeping this set small is deliberate, so that attention stays on what changes outcomes.

Indicator	What it tells us
Weekly maternal deaths	Immediate performance and early warning
Cumulative maternal deaths against 2025	Progress against the same period last year
Districts at or above last year	Which districts need surge support
Maternal deaths by cause	Where technical support should go
Reviews completed within seven days	Whether accountability is holding

Indicator	What it tells us
Actions completed on time	Whether reviews are leading to change
Weekly child deaths and admissions	Child survival and facility mortality
Child deaths within 24 hours of admission	Late presentation and emergency care gaps
Zero dose children vaccinated against target	Immunisation reach
Districts above 100 per cent of zero dose target	Where denominators need validation
Blood, oxygen and medicine stock-outs	Preventable readiness gaps

Annex F. Priority Public Health Messages

Kept short so they survive translation into every community.

Area	Key messages
Maternal	Bleeding in pregnancy or after delivery is an emergency; convulsions in pregnancy need immediate care; fever after delivery or surgery must be treated at once; severe headache, blurred vision or swelling can be danger signs; attend postnatal care; accept referral early; high-risk pregnancies should deliver in hospital
Child	A child with fast breathing needs urgent care; fever, convulsions, poor feeding and lethargy are danger signs; diarrhoea can kill if dehydration is not treated early; malaria can become severe quickly; malnourished children need early treatment; a newborn who is cold, not feeding or breathing poorly needs urgent care
Immunisation	Every child should be vaccinated; children who have never received a vaccine must be found; communities should help identify them; vaccination protects families and communities

Annex G. Chronology of Key Campaign Milestones

Date, 2026	Milestone
1 March	Launch of the 300 Days of Activism for Triple Zero
March to May	Regional engagement in Makeni and Bo; activation of district taskforces
7 to 12 June	Maternal and child health handbook supportive supervision, Moyamba, Pujehun and Bo, with JICA
16 June	300 Days taskforce meeting, Bombali emergency operations centre
22 June	Week 24 situation update
27 June	Blood donation drive with the Red Cross, Makeni
29 June	Focus group discussion on the campaign facilitated by MoICE, Bombali

Date, 2026	Milestone
30 June	Health presence at the Presidential Town Hall, Makeni, under the theme Year of Action
6 to 11 July	Comprehensive post-abortion care training, twenty participants, with DKT
9 July	Free Health Care commodity delivery to district medical stores, Bombali, by NMSA
13 to 19 July	Week 29 reporting period, the most recent validated data in this report
13 to 23 July	Health Service Commission nurse recruitment interviews across regional centres
15 July	National Safe Blood Service regional working group on the hub-and-spokes model, Makeni
28 July	Day 150, submission of this report

Annex H. Maternal and Child Deaths by Month

Reported deaths by month for the fully completed months January to June, both years. Weekly groupings into months are approximate at the boundaries.

Month	Maternal 2025	Maternal 2026	Child 2025	Child 2026
January	37	30	286	308
February	35	36	324	355
March	48	29	383	440
April	40	20	401	328
May	43	44	453	429
June	39	32	512	429

Annex I. Facility Readiness Rapid Check After Every Death

Readiness area	What is checked
Blood and transfusion	Blood available and screened; transfusion functioning around the clock
Emergency obstetric drugs	Oxytocin and other uterotonics, magnesium sulphate, antibiotics in stock
Child emergency supplies	Antimalarials, oxygen and pulse oximetry, intravenous fluids, paediatric emergency supplies
Referral and transport	Referral communication working; ambulance and emergency transport available
Staffing	Skilled staff present and reporting to assigned duty stations, including at night

Readiness area	What is checked
Documentation	Complete clinical records and referral notes; death reviewed within seven days

Annex J. The Death Review Action Tracker

Field	Purpose
District and facility	Where the death occurred
Cause of death	The clinical cause on review
Delay identified	Which of the three delays contributed
Root cause	The system reason behind the delay
Corrective action	What will be done to prevent recurrence
Responsible person	Who owns the action
Deadline	When it must be completed
Status and evidence	Whether it is done, with proof
Support required	What the district needs from national level or partners

Annex K. Emergency Obstetric and Newborn Care Signal Functions

The signal functions that define a facility's capacity to save a mother or newborn in an emergency [15]. A facility that cannot perform its expected functions is where the third delay turns into a death.

Level	Signal functions expected
Basic emergency obstetric and newborn care	Parenteral antibiotics; uterotonics for haemorrhage; parenteral anticonvulsants such as magnesium sulphate; manual removal of the placenta; removal of retained products; assisted vaginal delivery; basic newborn resuscitation
Comprehensive emergency obstetric and newborn care	All of the basic functions, plus caesarean section and blood transfusion

Annex L. Levels of the Health System

Referral works when each level knows what the next can do.

Level	Description
Community	Community health workers, traditional and religious leaders, women's groups; where care-seeking begins
Peripheral health unit	Maternal and child health posts, community health posts and community health centres, providing antenatal care, delivery, immunisation and basic emergency care
District and government hospital	Surgical and comprehensive emergency obstetric and newborn care, paediatric admission, blood transfusion
Regional hospital	Referral care for a region, specialist services, higher-dependency capacity
National and tertiary	Connaught Hospital, Princess Christian Maternity Hospital and Ola During Children's Hospital, the national referral points for the most complex cases

Annex M. A Note on Methods and Data Sources

Data sources. Maternal deaths are drawn from the district maternal death line lists that feed the weekly situation brief, which is held on a secure cloud-based platform. Child deaths and admissions are reported in the child health weekly returns submitted by the focal persons at each facility. Zero-dose figures come from the Expanded Programme on Immunisation, tracking against the national target of 9,006. All counts are provisional until the weekly validation is complete, and district totals may be revised as late reports arrive.

Comparisons. The campaign period maintains constant seasonality by comparing the same reporting weeks in 2026 and 2025, week by week. Weeks 10 to 27 are used for districts requiring a comparable window, as they are fully validated for both years. Cumulative watch-list positions are reported as they appear in the weekly brief.

Estimated lives saved. Deaths averted are estimated by projecting the pre-campaign level, trend and seasonality forward to describe what would likely have happened without the campaign, then comparing that with what occurred. The difference is reported as lives saved. This figure is an estimate offered to convey scale, and it agrees closely with the year-on-year reductions drawn independently from the weekly data.

Strength of the evidence. Whether the fall in deaths is likely to be real rather than chance is tested with interrupted time series analysis and with ARIMA models that account for the natural week-to-week variation in the series [2]. The maternal result is significant at a probability of 0.022. The child result, at about 0.057, is reported honestly as borderline and still building. Healthy years of life restored are expressed as disability-adjusted life years [12] and reflect impact already delivered, not a forecast.

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Annex O. Campaign Photo Gallery

A visual record of the first 150 days. Photographs should be captioned with the activity, the facility or district, and the date, and should be used only where consent has been obtained.



Photo 14: *Campaign launch, 2 March 2026*



Photo 15: *The CMO at the graduation ceremony of 30 neo-natal nurse*



Photo 16: *Ambulance and referral team responding to an obstetric emergency*



Photo 17: *A cross-section of MoH leadership at the PCMH 2025 annual report launching*



Photo 18: *Community health workers on an outreach round*



Photo 19: *A high-level delegation from the Ministry to Bo*

References

1. World Bank. Fertility rate, total (births per woman) – Sierra Leone. World Development Indicators. Washington (DC): World Bank; 2024. Available from: https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=SL
2. Bernal JL, Cummins S, Gasparrini A. Interrupted time series regression for the evaluation of public health interventions: a tutorial. Int J Epidemiol. 2017;46(1):348–355.
3. World Health Organization, UNICEF, UNFPA, World Bank Group, United Nations Department of Economic and Social Affairs (Population Division). Trends in maternal mortality 2000 to 2023: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2025.
4. United Nations Inter-agency Group for Child Mortality Estimation (UN IGME). *Levels and Trends in Child Mortality: Report 2024.* New York: UNICEF; 2024. Available from: https://childmortality.org
5. World Health Organization. *Global Health Observatory: Child Mortality and Causes of Death.* Geneva: WHO; 2024. Available from: https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/child-mortality
6. Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels J, et al. Global causes of maternal death: a WHO systematic analysis. Lancet Glob Health. 2014;2(6):e323–e333.
7. Perin J, Mulick A, Yeung D, Villavicencio F, Lopez G, Strong KL, et al. Global, regional, and national causes of under-5 mortality in 2000–19: an updated systematic analysis with implications for the Sustainable Development Goals. Lancet Child Adolesc Health. 2022;6(2):106–115.
8. Witter S, Brikci N, Harris T, Williams R, Keen S, Mujica A, et al. The Sierra Leone Free Health Care Initiative (FHCI): process and effectiveness review. Freetown/London: HEART/Oxford Policy Management; 2016. (The FHCI was launched by the Government of Sierra Leone in 2010, removing user fees for pregnant women, lactating mothers and children under five.)
9. World Health Organization. Immunization Agenda 2030: a global strategy to leave no one behind. Geneva: World Health Organization; 2020.
10. Thaddeus S, Maine D. Too far to walk: maternal mortality in context. Soc Sci Med. 1994;38(8):1091–1110.
11. World Health Organization. Maternal death surveillance and response: technical guidance. Information for action to prevent maternal death. Geneva: World Health Organization; 2013.
12. World Health Organization. WHO methods and data sources for global burden of disease estimates 2000–2019 (Global Health Estimates Technical Paper WHO/DDI/DNA/GHE/2020.3). Geneva: World Health Organization; 2020.
13. World Health Organization. WHO recommendations for the prevention and treatment of postpartum haemorrhage. Geneva: World Health Organization; 2012.
14. The Magpie Trial Collaborative Group. Do women with pre-eclampsia, and their babies, benefit from magnesium sulphate? The Magpie Trial: a randomised placebo-controlled trial. Lancet. 2002;359(9321):1877–1890.
15. World Health Organization, UNFPA, UNICEF, Averting Maternal Death and Disability (AMDD). Monitoring emergency obstetric care: a handbook. Geneva: World Health Organization; 2009.
16. World Health Organization. WHO recommendations on antenatal care for a positive pregnancy experience. Geneva: World Health Organization; 2016.

17. World Health Organization. Oxygen therapy for children: a manual for health workers. Geneva: World Health Organization; 2016.
18. World Health Organization. Emergency Triage Assessment and Treatment (ETAT): manual for participants. Geneva: World Health Organization; 2005.
19. World Health Organization. Guideline: updates on the management of severe acute malnutrition in infants and children. Geneva: World Health Organization; 2013.
20. Statistics Sierra Leone (Stats SL) and ICF. Sierra Leone Demographic and Health Survey 2019. Freetown, Sierra Leone, and Rockville, Maryland, USA: Stats SL and ICF; 2020.