LIVABLE AFFORDABLE

A Health System That Works When It Is Needed

Health, nutrition & wellbeing

> *A mother carries her feverish child to the nearest clinic, only to find no nurse on duty, no medicine on the shelf, and a long walk to the next town for a diagnosis that might come too late.*

WHY THIS MATTERS

Sierra Leone has roughly a quarter of the health workers the minimum standard calls for, and a “free” healthcare policy that too often breaks down at exactly the moment a family needs it — not because the policy is wrong, but because the staff, medicine, and the means to actually diagnose what's wrong haven't kept up. A promise of free care that still leaves a mother paying out of pocket, or a clinician guessing because there's no lab to test with, isn't free care; it's a disappointment dressed as a policy.

WHAT WE'RE PROMISING

A health system that works when it is needed, judged not by clinics opened but by lives actually saved.

FLAGSHIP — Salone Welbody

Sierra Leone has a deep bench of doctors and specialists it doesn't currently use — its own medical diaspora, serving in hospitals across the world. A national telemedicine and visiting-missions programme will draw on them: structured, paid visiting missions, real-time telemedicine links that let a district doctor consult a specialist abroad in the moment a patient needs it, and teaching appointments so diaspora and visiting specialists train the next generation of Sierra Leonean doctors while they treat patients here. This is a bridge, not a destination — it covers today's gap while we train our own specialists to fill it permanently, and it turns the diaspora from a source of remittances into a source of the rarest thing we lack: skill at the bedside.

HOW WE'LL MAKE IT REAL

- We'll expand training for doctors, nurses and midwives, but just as importantly, we'll keep them once trained — through reliable pay, housing and incentives for those who serve in rural, underserved areas, because a health worker who isn't paid on time or supported will leave, and the training investment leaves with them.
- We'll close the diagnostic gap that leaves clinicians guessing instead of treating. Where there's no laboratory, no test and no imaging, illness is guessed at rather than diagnosed, and where there's no blood, a haemorrhaging mother or an injured child simply dies. We'll invest in laboratory capacity across the regions and districts — not only the equipment, but the trained technicians to run it, since one without the other is useless — and strengthen diagnostic testing, imaging and the national blood supply that safe surgery and safe childbirth depend on.
- With crashes a leading cause of death and almost nothing between the major towns to treat the badly hurt, we'll establish trauma and emergency care capacity along the main highway corridor, linked to the national ambulance service, so an accident far from a city is no longer effectively a death sentence.
- We'll make free care actually free for those who need it most, through a health equity fund that identifies the poorest roughly one million citizens through the national social registry and pays facilities for the care they actually deliver to those patients — not for inputs that too often vanish — so the money pulls the whole system toward performance rather than just paying bills.

- We'll fix the medicine pipeline with real-time, transparent stock visibility, tackling a supply chain where drugs meant to be free are too often diverted and sold instead of reaching the patient they were bought for.

> *“A clinic with no health worker, no diagnosis, and no medicine is not a health service. It is an empty building with a sign.”*