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IDA/R2016-0130/1

June 6, 2016

Closing Date: Thursday, June 23, 2016 at 6 p.m.

FROM: Vice President and Corporate Secretary

Sierra Leone - Health Services Delivery and System Support Project

Project Appraisal Document

Attached is the Project Appraisal Document regarding a proposed credit to Sierra Leone for a Health Services Delivery and System Support Project (IDA/R2016-0130), which is being processed on an absence-of-objection basis.

Distribution:
Executive Directors and Alternates
President
Bank Group Senior Management
Vice Presidents, Bank, IFC and MIGA
Directors and Department Heads, Bank, IFC and MIGA

Document of
The World Bank

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Report No: PAD1633

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 7.1 MILLION

(US$10 MILLION EQUIVALENT)

AND A

PROPOSED GRANT FROM THE

EBOLA RECOVERY AND RECONSTRUCTION TRUST FUND

IN THE AMOUNT OF US$5.5 MILLION

TO THE

REPUBLIC OF SIERRA LEONE

FOR A

HEALTH SERVICE DELIVERY AND SYSTEM SUPPORT PROJECT

May 27, 2016

Health, Nutrition and Population Global Practice
Africa Region

CURRENCY EQUIVALENTS
(Exchange Rate Effective as of March 31, 2016
Currency Unit = Sierra Leonean Leone (SLL)
3900 = US$1
US$ = SDR 0.70981389

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AfDB	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
BPEHS	Basic Package of Essential Health Services
BCR	Benefit-Cost Ratio
CE	Citizen Engagement
CER	Contingency Emergency Response
CHO	Community Health Officer
CHW	Community Health Worker
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CPD	Continuing Professional Development
CPF	Country Partnership Framework
DA	Designated Account
DALY	Disability-Adjusted Life Years
DDMS	Directorate of Drugs and Medical Supplies
DEHS	Directorate of Environmental Health and Sanitation
DFID	U.K. Department for International Development
DH	District Hospital
DHL	Directorate of Hospitals and Laboratories
DHMT	District Health Management Team
DHS	Demographic Health Survey
DPHC	Directorate of Primary Health Care
DPI	Directorate of Health Systems, Policy, Planning and Information
DRCH	Directorate of Reproductive and Child Health
DSS	Directorate of Support Services
EERP	Emergency Ebola Response Project
EMS	Emergency Medical Services
ERRTF	Ebola Recovery and Reconstruction Trust Fund
ESICOME	Expanded Sanitary Inspection Compliance and Enforcement
ESMF	Environmental and Social Management Framework

EVD	Ebola Virus Disease
FBS	Selection under a Fixed Budget
FHCI	Free Health Care Initiative
FM	Financial Management
FA	Financing Agreement
FMC	Facility Management Committee
FMT	Foreign Medical Team
GAVI	Global Alliance for Vaccine Initiative
GoSL	Government of Sierra Leone
GRS	Grievance Redress Service
HMIS	Health Management Information System
HSCC	Health Sector Coordinating Committee
HSDSSP	Health Service Delivery and System Support Project
HSS	Health Systems Strengthening
IC	Selection of Individual Consultants
ICB	International Competitive Bidding
IFC	International Finance Corporation
IFR	Interim Financial Report
IHPAU	Integrated Health Project Administration Unit
IMF	International Monetary Fund
IP	Implementing Partner
IRM	Immediate Response Mechanism
IRR	Internal Rate of Return
JICA	Japanese International Cooperation Agency
LC	Local Council
LCS	Least-Cost Selection
LYS	Life Years Saved
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDSR	Maternal Death Surveillance and Response
MEST	Ministry of Education, Sciences, and Technology
MoFED	Ministry of Finance and Economic Development
MoHS	Ministry of Health and Sanitation
NCB	National Competitive Bidding
NGO	Nongovernmental Organization
NHSSP	National Health Sector Strategic Plan
NPPA	National Public Procurement Authority
NPPU	National Pharmaceutical Procurement Unit
PBF	Performance-Based Financing
PDO	Project Development Objective
PFM	Public Financial Management

PHA	Public Health Aide
PHC	Primary Health Care
PHI	Public Health Inspector
PHU	Peripheral Health Unit
PIM	Project Implementation Manual
PPA	Project Preparation Advance
PPP	Public-Private Partnership
PRSP	Poverty Reduction Strategy Paper
QBS	Quality-Based Selection
QCBS	Quality- and Cost-Based Selection
RCHP2	Reproductive and Child Health Project
REDISSE	Regional Disease Surveillance Systems Enhancement Project
SBD	Standard Bidding Document
SCD	Systematic Country Diagnostic
SLA	Service-Level Agreement
SLCPGCHS	Sierra Leone Council for Post-Graduate Colleges of Health Specialties
SPN	Specific Procurement Notice
SSS	Single-Source Selection
THCA	Teaching Hospital Complex Administration
TOR	Terms of Reference
TT	Tetanus Toxoid
UN	United Nations
UNDB	United Nations Development Business
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VDC	Village Development Committee
WHO	World Health Organization

Regional Vice President:	Makhtar Diop
Country Director:	Henry G. R. Kerali
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Trina S. Haque
Task Team Leader:	Francisca Ayodeji Akala

SIERRA LEONE
Health Service Delivery and System Support Project

TABLE OF CONTENTS

Page

LIST OF FIGURES

LIST OF TABLES

PAD DATA SHEET

Sierra Leone

Health Service Delivery and System Support Project (P153064)

PROJECT APPRAISAL DOCUMENT

AFRICA

GHN07

Report No.: PAD1633

Basic Information		
Project ID P153064	EA Category B - Partial Assessment	Team Leader(s) Francisca Ayodeji Akala
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [X] Financial Intermediaries [ ] Series of Projects [ ]	
Project Implementation Start Date 20-June-2016	Project Implementation End Date 30-Sep-2019	
Expected Effectiveness Date 30-Sep-2016	Expected Closing Date 30-Sep-2019	
Joint IFC No		

Practice Manager/Manager	Senior Global Practice Director	Country Director	Regional Vice President
Trina S. Haque	Timothy Grant Evans	Henry G. R. Kerali	Makhtar Diop

Borrower: Republic of Sierra Leone			
Responsible Agency: Ministry of Health and Sanitation			
Contact:	Abu Bakar Fofanah	Title:	Minister of Health and Sanitation
Telephone No.:	23279899931	Email:	mohs.2014@yahoo.com

Project Financing Data(in US$, millions)					
[ ]	Loan	[ ]	IDA Grant	[ ]	Guarantee
[X]	Credit	[X]	Grant	[ ]	Other

Total Project Cost:	15.50	Total Bank Financing:	15.50
Financing Gap:	0.00		

Financing Source	**Amount**
BORROWER/RECIPIENT	0.00
International Development Association	10.00
Ebola Recovery and Reconstruction Trust Fund	5.50
Total	15.50

Expected Disbursements (in US$, millions)

Fiscal Year	2016	2017	2018	2019						
Annual	2.00	6.50	4.00	3.00						
Cumulative	2.00	8.50	12.50	15.50						

Institutional Data

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Education

Cross Cutting Topics

[ ] Climate Change
[ ] Fragile, Conflict & Violence
[X] Gender
[X] Jobs
[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	50		
Health and other social services	Other social services	50		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes		
Theme (Maximum 5 and total % must equal 100)		
Major theme	Theme	%
Human development	Health system performance	50
Human development	Population and reproductive health	35
Human development	Other human development	10
Human development	Child health	5
Total		100

Proposed Development Objective(s)

The project development objectives are to (a) increase the utilization and improve the quality of essential maternal and child health services; and (b) in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

Components

Component Name	Cost (US$, millions)
Health Service Delivery	11.10
Health System Support	4.40
Contingency Emergency Response	0.00

Systematic Operations Risk-Rating Tool (SORT)

Risk Category	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
OVERALL	Substantial

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]
Does the project require any waivers of Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [ ]

Is approval for any policy waiver sought from the Board?	Yes [ ] No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X] No [ ]

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	X	
Natural Habitats OP/BP 4.04		X
Forests OP/BP 4.36		X
Pest Management OP 4.09		X
Physical Cultural Resources OP/BP 4.11		X
Indigenous Peoples OP/BP 4.10		X
Involuntary Resettlement OP/BP 4.12		X
Safety of Dams OP/BP 4.37		X
Projects on International Waterways OP/BP 7.50		X
Projects in Disputed Areas OP/BP 7.60		X

Legal Covenants

Name	Recurrent	Due Date	Frequency

Description of Covenant

Conditions

Source of Fund	Name	Type
IDA	Ebola Recovery and Reconstruction Trust Fund (ERRTF)	Effectiveness

Description of Condition

FA Article IV. 4.01 (a). The ERRTF Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals it (other than the effectiveness of this Agreement) have been fulfilled.

Source of Fund	Name	Type
ERR	Ebola Recovery and Reconstruction Trust Fund (ERRTF)	Effectiveness

Description of Condition

GA Article IV. 4.01 (a). The Financing Agreement and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under the Financing Agreement (other than the effectiveness of the Grant Agreement) have been fulfilled.

Source of Fund	Name	Type
IDA	Project Steering Committee	Effectiveness

Description of Condition

FA Article IV. 4.01 (b). The Recipient has established the Project Steering Committee in accordance with the provisions of Section I.A (2) of Schedule 2 of the FA (The Recipient shall maintain throughout Project implementation, a Project Steering Committee with membership and terms of reference satisfactory to the Association and with adequate resources to carry out its responsibilities under the Project).

Source of Fund	Name	Type
IDA	Staffing of IHPAU and Computerized Software	Effectiveness

Description of Condition

FA Article IV. 4.01 (d). The Recipient has employed or assigned to the IHPAU required personnel including accountants, finance assistants and procurement officers, all with qualifications and experience satisfactory to the Association; and has procured and installed computerized accounting software satisfactory to the Association.

Source of Fund	Name	Type
IDA	Project Implementation Manual	Effectiveness

Description of Condition

FA Article IV. 4.01 (c). The Recipient has adopted the Project Implementation Manual in accordance with the provisions of Section I.B of the Schedule 2 of the FA.

Source of Fund	Name	Type
IDA	Crisis or Emergency	Disbursement

Description of Condition

FA Schedule 2. Section IV. B. 1 (e). No withdrawal shall be made under Emergency Expenditures under Component 3 of the Project (Category 12) unless and until the World Bank is satisfied, and notified the Recipient of its satisfaction, that all of the following conditions have been met in respect of said activities:

1. the Recipient has determined that an Eligible Crisis or Emergency has occurred and has furnished to the Association a request to include said activities in the IRM Part in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof;
2. the Recipient has prepared and disclosed all safeguards instruments required for said activities, and the Recipient has implemented any actions which are required to be taken under said instruments, all in accordance with the provisions of Section I.C.3 of Schedule 2 of the FA.
3. the Recipient's Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section I.C.2 of Schedule 2 of the FA, for the purposes of said activities; and
4. the Recipient has adopted an IRM Operations Manual in form, substance and manner acceptable to the World Bank and the provisions of the IRM Operations Manual remain -or have been updated in accordance with the provisions of Section I.C.1 of Schedule 2 of the FA so as to be - appropriate for the inclusion and implementation of said activities under the IRM Part.

Source of Fund	Name	Type
IDA	Community Health Workers Program	Disbursement

Description of Conditions

FA Schedule 2. Section IV. B. 1 (c). No withdrawal shall be made under this program (Categories 1 and 2) unless:

1. the Recipient has prepared a plan to deploy Community Health Workers (CHWs) in hard-to-reach areas of the country (defined as communities that are more than 5 km or more than one hour's walk from a health facility) and this plan has been signed off by (i) the Human Resource Management Office, (ii) the Public Service Commission/Health Service Commission, and (iii) the MoFED to ensure the future sustainability of these CHWs after the end of the project; and
2. the Recipient has adopted the Community Health Workers Deployment and Incentives Plan; and with respect to Incentive Payments, the Recipient has provided evidence that the proposed payments are to be made in respect of Eligible Community Health Workers that have met the performance criteria and other requirements set out in the Project Implementation Manual and Section I.F of Schedule 2 of the FA.

Source of Fund	Name	Type
IDA	Stipends to Eligible Post-Graduate Medical Students and Eligible Trainee Nurses	Disbursement

Description of Conditions

FA Schedule 2. Section IV. B. 1 (d). No withdrawal shall be made under the stipend program (Category 7) unless and until the Recipient has provided evidence that the proposed payments are to be made in respect of Eligible Post-Graduate Medical Students and Eligible Trainee Nurses that have met the requirements set out in the Project Implementation Manual and Section I.G of Schedule 2 of the FA.

Bank Staff Name	Role	Title	Specialization	Unit
Francisca Ayodeji Akala	Team Leader (ADM Responsible)	Senior Health Specialist	Technical (Health) and Project Management	GHN06
Richard Olowo	Procurement Specialist (ADM Responsible)	Lead Procurement Specialist	Procurement	GCFDR
Ismaila B. Ceesay	Financial Management Specialist	Lead Financial Management Specialist	Financial Management	GGO25
Aissatou Chipkaou	Team Member	Operations Analyst	Operations Quality	GHN07
Alix Mary Louise Bonargent	Team Member	Consultant	Technical (Health)	GHN07
Demba Balde	Team Member	Senior Social Development Specialist	Social Safeguards	GSU01
Michael Gboyega Ilesanmi	Safeguards Specialist	Consultant	Social Safeguards	GSU01

Dominic S. Haazen	Team Member	Lead Health Policy Specialist	Technical (Health)	GHN07
Innocent Kamugisha	Team Member	Procurement Specialist	Procurement	GGO01
Maiada Mahmoud Abdel Fattah Kassem	Finance Officer	Finance Officer	Disbursement	WFALA
Mugambi Mugisha Mwendia	Team Member	Finance Analyst	Disbursement	WFALA
Peter D. Bachrach	Team Member	Consultant	Technical (Health) & Project Management	GHN07
Raihona Atakhodjayeva	Team Member	Operations Analyst	Operations Quality	GHN07
Ruma Tavorath	Safeguards Specialist	Senior Environmental Specialist	Environment Specialist	GEN07
Salieu Jalloh	Team Member	Team Assistant	Team Assistant	AFMSL
Sariette Jene M. C. Jippe	Team Member	Program Assistant	Team Assistant (Operations and administration)	GHN07
Sheikh Alhaji Yayah Sesay	Team Member	Operations Officer	Operations	AFMSL
Shunsuke Mabuchi	Team Member	Senior Health Specialist	Technical (Health)	GHN07
Stephen Mugendi Mukaindo	Country Lawyer	Counsel	Legal	LEGAM
Eleonora Genovese	Team Member	Health Specialist	Technical (Health)	GHN07
Sybille Crystal	Team Member	Senior Operations Officer	Operations Quality	GHN07
Sydney Augustus Olorunfe Godwin	Team Member	Financial Management Specialist	Financial Management	GGO31
Fatu Karim-Turay	Team Member	Executive Assistant	Team Assistant	AFSML

Extended Team	**Title**	**Office Phone**	**Location**
Name			

Locations	First Administrative Division	Location	Planned	Actual	Comments
Country					

Consultants (Will be disclosed in the Monthly Operational Summary)	Consulting services to be determined
Consultants Required?	

I. STRATEGIC CONTEXT

A. Country Context

1. **Following the end of the civil war in 2002, Sierra Leone experienced a period of rapid growth.** Due largely to political stability and the return of large numbers of the population to agriculture and related activities, gross domestic product (GDP) increased nearly 6 percent annually through 2010. More recently, the growth of the iron ore industry together with large inflows of foreign direct investment and exports of new iron ore production raised annual GDP growth rates to an average 17.6 percent from 2010 to 2013.[1] Substantial potential exists for further development of the country's mineral resources and commercial agriculture and fishing.

2. **Nevertheless, Sierra Leone is regularly placed at the bottom of global rankings of well-being.**[2] Though poverty declined between 2003 and 2011 for the country's approximately 6 million residents (from 66.4 percent to 52.9 percent), the number of poor people has remained essentially constant (around 3 million) due to higher rates of fertility. More than three-quarters of the poor live in rural areas with relatively small regional differences between rural areas across the country.

3. **The most recent Poverty Reduction Strategy Paper (PRSP) has set the ambitious goal of achieving middle-income country status by 2035.** Reflecting the positive economic advances, the 'Agenda for Prosperity'[3] has established annual per capita expenditure growth targets of 4.8 percent. The Systematic Country Diagnostic (SCD) currently under preparation notes, however, that per capita growth of this magnitude would require GDP growth of around 9 percent annually, substantially higher than the average 6.4 percent achieved between 2003 and 2013. In addition, while recognizing that management of the economy had been effective in achieving growth and macroeconomic stability, the 2013 International Monetary Fund (IMF) program review also cautioned that the small revenue base and persistent pressures on government expenditure could threaten this stability. This was subsequently demonstrated by the derailing of the government's economic program during the recent Ebola epidemic.[4]

4. **Though Sierra Leone has effectively been Ebola free since November 2015, the epidemic had devastating consequences for the country.** As of February 15, 2016, an estimated 14,114 cases and 3,956 deaths had been recorded in Sierra Leone.[5] Among the direct victims of the epidemic were 446 children, while 8,345 children were orphaned and more than 1,100 households were left with a single parent.[6] Apart from the direct human cost with regard to lost lives and livelihoods, the epidemic had a disproportionately large effect on economic activity: the SCD indicates a decline (from the midyear projection of an 11.3 percent increase in real GDP) of

[1] However, the overall GDP per capita increase of 78 percent between 2003 and 2011 was below the Sub-Saharan average of 132 percent.
[2] The United Nations' (UN's) 2015 Human Development Index ranked Sierra Leone 181st out of 188 countries and territories (http://report.hdr.undp.org/)
[3] The Agenda for Prosperity is Sierra Leone's third-generation PRSP covering the period 2013–2018.
[4] The World Bank estimates that GDP declined by more than 20 percent during 2014–2015, leading to losses of some US$1.4 billion and a collapse of domestic revenue. Macroeconomics and Fiscal Management, Recent Economic Developments (September 2015).
[5] Ebola Situation Summary, WHO, December 4, 2015.
[6] Government of Sierra Leone. 2015. *National Ebola Recovery Strategy*.

around 5 percentage points for economic growth in 2014. While preliminary information suggests that the economic effects of Ebola in 2014 were partially offset by continued rapid expansion in the iron ore sector (albeit at slower than expected rates), the trajectory and timing of an economic recovery from the epidemic remain unclear.

5. Further, data from the first round of the high-frequency cell phone surveys, conducted in November 2014, suggest declines in employment, high food insecurity, and reduced utilization of services, which have the potential to negatively affect both short- and long-term household well-being. While the survey found no significant impact on smallholder agriculture, there were large effects on household enterprises and significant declines in employment in urban areas (7 percentage points), particularly among the nonfarm self-employed. Youth are especially vulnerable, with the employment rate among youth in some urban areas declining more steeply than among workers overall and youth in rural areas experiencing a larger drop in hours worked. Female-headed households are also particularly vulnerable as they are disproportionately working in the hard-hit nonfarm self-employment sector.

B. Sectoral and Institutional Context

6. **Before the Ebola epidemic, the health sector already faced many critical foundational challenges.** These included (a) chronic imbalances between the high level of health expenditures and the country's poor health outcomes; (b) insufficient access to health services resulting from poorly equipped health facilities and uneven distribution of inadequate numbers of health personnel; (c) weak capacity for effective implementation, coordination, and monitoring and evaluation (M&E) of policies and projects; and (d) an inadequate surveillance and emergency preparedness capacity.

7. **Despite Sierra Leone's significant health expenditures, health outcomes are worse than in countries with comparable socioeconomic characteristics.** From 2004 through 2012, total health expenditure as a percent of GDP ranged between 14 percent and 16 percent, and per capita spending on health increased from US$69 (2010) to US$82 (2011) to US$96 (2012). Overall, however, government expenditures represent only 6.8 percent of total health expenditures,[7] while donor financing accounts for 24.4 percent and nongovernmental organization (NGO) funding for 7.2 percent. The bulk of health spending, despite the introduction of the Free Health Care Initiative (FHCI) in 2010, is out of pocket and accounts for 61.6 percent[8] of financing. In addition to the inadequate amounts of public funding, the timeliness of its release is problematic.[9]

8. Sierra Leone's maternal and child health (MCH) outcomes remain among the world's worst: (a) maternal mortality is estimated at 1,165 per 100,000 live births; (b) infant mortality is

[7] Part of the reason for this poor performance is that the government's total revenue is only 13 percent of GDP, compared with the minimum target of 20 percent. According to the IMF, Sierra Leone is one of 32 countries in the world with total government revenue below 20 percent of GDP.

[8] According to the National Health Accounts (2013), out-of-pocket expenditures are well above the recommended limit of 20 percent with the risks of excluding the poorest from care and exposing them to financial catastrophe and impoverishment.

[9] According to the Budget Advocacy Working Group (2015), funds for health were released four months late on average between 2010 and 2013. In 2013, 11 percent of budgeted health funds were not released at all.

estimated at 92 per 1,000 live births; and (c) under-five mortality is estimated at 156 per 1,000 live births.[10] These results are far from the Millennium Development Goals of 450 per 100,000 live births, 50 per 1,000 live births, and 95 per 1,000 live births, respectively, expected by the end of 2015.

9. The maternal mortality ratio steadily declined through 2008 but has remained stable since. The most recent Demographic Health Surveys (DHSs) show the maternal mortality ratio at 857 per 100,000 live births (2008) and 1,165 per 100,000 live births (2013), but the increase is not statistically significant. Other reproductive health indicators have improved over 2008–2013: (a) the proportion of pregnant women seeking antenatal care reached 97 percent in 2013; (b) institutional delivery and delivery by trained health workers increased from 42.4 percent to 59.7 percent;[11] and (c) fertility rates among adolescents (15 to 19 years old), while high, have declined slightly from 149 per 1,000 women to 125 per 1,000 women. Contraceptive prevalence remains very low at 16 percent.

10. Among children ages 6 to 59 months, malaria is the most common cause of illness and death, with a prevalence of 43 percent (48 percent in rural areas and 28 percent in urban areas). Chronic malnutrition (stunting) is widespread, varying between 35 to 45 percent of children under five years and showing no signs of improvement between 2000 and 2010; over the same period, acute malnutrition has declined very slowly from 11.5 percent to 9 percent of children under five years. Other main causes of illness and death in children are acute respiratory infections and diarrhea. In 2013, 68 percent of children ages 12 to 23 months have received all of the recommended vaccinations and only 4 percent of the children did not receive any type of vaccination.

11. Access to drinking water is a serious concern, especially in rural areas (where less than half of all households have access to improved source of drinking water) and during the dry season. The country has failed to implement a functioning waste management system, and only 10 percent of households use an individual improved toilet facility.[12]

12. **Physical and financial access to primary health care (PHC) is limited, despite the government's FHCI.** The DHS (2013) found that 38 percent of women interviewed (over 50 percent in rural areas) had issues with distance and transportation, and 67 percent stated that cost was a serious problem. Service readiness is generally low, as most facilities lack the trained staff and equipment required to provide those services they are supposed to deliver. End users also complained of the quality of services (staff absenteeism and attitudes, drug stock-outs, illegal fees, and so on). However, Sierra Leone lacks effective structures allowing patients to channel their complaints and grievances about the health care system.[13]

[10] All figures from the DHS (2013), except life expectancy from the Global Health Observatory.
[11] Contrary to World Health Organization (WHO) guidelines, MCH aides and nurses are accounted as skilled birth attendants in the DHS and health management information system (HMIS).
[12] All figures in the paragraph from the DHS (2013).
[13] Under the Bank-financed Decentralized Service Delivery Program (Phase 2), a grievance redress mechanism is being established. An implementation manual has been prepared, the grievance redress mechanism is being piloted for a number of ministries (including the MoHS) and in five (of thirteen) districts, and an assessment is planned for early 2016.

13. **Health human resources are particularly limited.** The overall ratio of skilled workers to population is 2/10,000 compared to the WHO minimum of 23/10,000, and these ratios are even lower for certain essential cadres: medical doctors 0.2/10,000, nurses 1.8/10,000, and midwives 0.2/10,000.[14] This scarcity of service providers has been further exacerbated by the exodus of health workers abroad and (more recently) the loss of staff to Ebola, with infections among health care workers resulting in 221 deaths, including 11 specialized physicians.[15] Health human resource planning and management is challenging: (a) workforce requirements and recruitment involve not only the Ministry of Health and Sanitation (MoHS) but also the Ministry of Finance and the Civil Service Commission; (b) training requires collaboration between the MoHS and the Ministry of Education, which manages the institutions along with the private sector; and (c) staff deployment remains centralized despite the orientations of the Decentralization Act.

14. **According to the current legislation, responsibilities for delivering public health services are shared.** At the central level, the MoHS is responsible for overall strategic direction, resource mobilization, and M&E of health services. At the district level, the District Health Management Team (DHMT) represents the MoHS and, with local council (LC) oversight, is responsible for planning, managing, monitoring, and supervising all health programs in the district. At the community level, LCs are responsible for primary health service delivery. In practice, however, the decentralization process has only been partial, and LCs have little capacity to fulfill their functions, which are being carried out by the MoHS. As devolution of sectoral staff was never implemented (for example, health personnel are still recruited and managed by the MoHS), LCs have no direct control over the staff responsible for health service delivery and the DHMT, which tends to report directly to its parent ministry.

15. **At the conclusion of the Ebola epidemic, Sierra Leone's already weak health system is confronting four important problems.** First, though 96 percent of primary health units remained open during the epidemic, community confidence in the health sector declined, negatively affecting utilization, with drops of 23 percent in institutional deliveries, 21 percent in children receiving basic immunization (penta3), and 39 percent in children treated for malaria.[16] Second, increased expenditures for the Ebola response reduced the resources available for the health sector to deal with other normally treatable conditions, leading to increases in malaria, measles, and other vaccine preventable diseases. Third, as reported recently in a Bank working paper, the loss of health care workers will have a significant impact on future non-Ebola mortality: after Ebola is eliminated, the Bank review estimates that maternal mortality could increase by 74 percent in Sierra Leone unless key doctors, nurses, and midwives are immediately hired.[17]

16. Fourth, due to the persistence of the Ebola virus in body fluids of survivors and its presence in animal reservoirs in West Africa, new cases are expected to arise in the region. Consequently, various experts[18] emphasize the need to address potential public health emergencies now to ensure

[14] MoHS. 2012. *Health Sector Performance Report*.
[15] Ebola Situation Summary, WHO, September 16, 2015.
[16] Building plan for Sierra Leone, World Bank
[17] David K Evans, et al. 2015. *The Next Wave of Deaths from Ebola? The Impact of Health Care Worker Mortality Data.* Policy Research Working Paper No. 7344. World Bank.
[18] Wright, S. et al. 2015. A Wake-Up Call: Lessons from Ebola for the World's Health Systems; Denney, L. et al. 2015. *After Ebola: Why and How Capacity Support to Sierra Leone's Health Sector Needs to Change.* Overseas Development Institute, London.

that systems and resources are in place to respond effectively to future outbreaks, including Ebola, and to help Sierra Leone become compliant with the International Health Regulations (IHR).

C. Higher Level Objectives to which the Project Contributes

17. **The government's 'Agenda for Prosperity' (2013–2018) aims to promote inclusive growth, economic diversification, and value addition.** Pillar 3 (Accelerating Human Development) of this paper accelerates human development, emphasizing health, human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS), water, and environmental sanitation and hygiene in particular. Initiatives to offer free health care and scale up nutrition activities feature prominently in the president's introductory message and in the vision for 2035. Pillar 8 (Gender and Women's Empowerment) also includes elements contributing to the health of women and girls.[19]

18. **As a consequence of the epidemic, implementation of the agenda has been temporarily suspended.** Currently, the government's Recovery and Transition Plan (April 2015) includes a broad range of priorities (health, education, social protection, and so on), and a 2-year plan is being prepared to return the country to the Agenda for Prosperity. The MoHS has also prepared a Post-Ebola Health Sector Recovery Plan (2015–2020),[20] which comprises three overlapping phases: early recovery (July 2015–March 2016), recovery (April 2016–December 2017), and health system strengthening and resilience building (2018–2020).[21]

19. **The Bank is preparing a new Country Partnership Framework (CPF).** As part of the CPF process, a draft of the SCD has been prepared (and used in the analysis above); the CPF will be available during FY2017. The Bank's existing Country Assistance Strategy 2010–2013 included 'Human Development' as one of the two principal pillars and focused on investments to support decentralized delivery of reproductive and child health services to address maternal and child mortality.

20. **The proposed project will be entirely consistent with the existing Bank priorities.** The Bank's pre-Ebola experience in the health sector of Sierra Leone dates to the 1980s and encompasses both health service delivery and health systems development (and decentralization). The ongoing Reproductive and Child Health Project (RCHP2) has since 2010 supported the LCs with grants to finance inputs and training (the need-based portion of the grant) and outputs (the performance-based portion of the grant). Additional financing was approved in 2013 to (a) strengthen the existing PHC performance-based financing (PBF); (b) extend PBF to private PHC providers; and (c) scale up the PBF mechanism from two to eight hospitals.[22] In 2014, the project was restructured to reallocate project funds in response to the Ebola epidemic.

[19] The Joint IDA-IMF Advisory Team assessed the Agenda for Prosperity positively but noted that many of the issues that impeded smooth implementation of the previous PRSP had not been addressed.
[20] MoHS, Health Sector Recovery Plan (2015–2020) (June 2015).
[21] Planning data are from the Global Fund Health Systems Support Proposal.
[22] The additional financing also financed (a) prevention services by financing long lasting impregnated nets; (b) capacity-building of the MoHS to carry out its oversight functions; and (c) assistance for the introduction of a social health insurance scheme for Sierra Leone.

21. Currently, several related operations provide instruments for the Bank's response to the Ebola epidemic: (a) the RCHP2 and (b) the Emergency Ebola Response Project (EERP).[23] The EERP is financing elements of the getting to zero and early recovery phases. The Health Service Delivery and System Support Project (HSDSSP), which includes the Ebola Recovery and Reconstruction Trust Fund (ERRTF) Grant of US$5.5 million, will continue support for the EERP and contribute to the key priorities of the ministry's Post-Ebola Recovery Plan: (a) patient and health worker safety; (b) health workforce; (c) essential health services; (d) community ownership; and (e) information and surveillance. Finally, the Bank is currently preparing a regional project to strengthen public health laboratory and disease surveillance capabilities throughout West Africa, including in the Ebola-affected countries.

22. **Though many other development partners are actively involved in the post-Ebola planning and implementation process, the Bank's contribution will be significant.** The project will be complementary to ongoing efforts by the development partners in Sierra Leone to support the post-Ebola recovery efforts. These partners include the UN agencies (WHO, United Nations Children's Fund [UNICEF], United Nations Population Fund [UNFPA], and so on); multilateral and bilateral agencies (Global Fund, African Development Bank [AfDB], U.K. Department for International Development [DFID], U.S. Agency for International Development [USAID], and so on); and foundations and NGOs. Annex 6 summarizes the complementary nature of the Bank's combined interventions and those of the other partners.

23. The Bank's contribution will be important for several reasons. First, though it is financed through different operations, the Bank's portfolio responds to the government's need to implement a comprehensive program of complementary responses: recovery, development, and surveillance. Second, because several of these operations are being implemented regionally, the Bank offers a perspective that other partners cannot, enabling Sierra Leone to benefit from both national and regional experiences in responding to the epidemic. Combined with the Bank's commitment to information sharing and collaboration, the project will provide a means for increasing coordination. Third, unlike virtually all of the other partners, the Bank-financed HSDSSP will disburse funds and implement activities through the existing MoHS structures, thereby strengthening and empowering them rather than creating parallel structures that have contributed to the fragmentation of the sector. Fourth, the flexibility of Bank financing, which has been useful for the MoHS during project preparation, will allow the project to fill gaps as needed during implementation. Finally, the rationale for Bank financing derives from both the moral imperative and the economic benefits of dramatically reducing maternal death.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

24. The project development objectives (PDOs) are to (a) increase the utilization and improve the quality of essential maternal and child health services; and (b) in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

[23] The Bank has also provided direct support through the Emergency Economic and Fiscal Support Operation (P146726) and restructuring of existing operations.

The government has requested the inclusion of an Immediate Response Mechanism (IRM) in the form of a Contingency Emergency Response (CER) component.

25. The PDO will be achieved by (a) developing initiatives to strengthen the organization and delivery of health services at the district and community levels; (b) increasing the numbers and improving the quality of essential health cadres; and (c) enhancing the ministry's capacity to plan, coordinate, and monitor interventions in the health sector. Combined with a restructured EERP, the HSDSSP comprises both an evolving response to the lingering effects of the epidemic and complementary investments in the future development of Sierra Leone's health sector.

Project Beneficiaries

26. **At the community and district levels, the principal beneficiaries will be pregnant women and children less than twelve months old.** Pregnant women, in particular, will benefit from the combined interventions of (a) antenatal care and detection (at the community and peripheral health unit [PHU] levels); (b) assisted delivery and postnatal care at the PHU and district hospital (DH) levels; and (c) if necessary, emergency transport from communities/PHUs to district or regional hospitals.

27. Project support will be national in scope, except for the Community Health Worker (CHW) Program, which will target the most hard-to-reach areas of the country, defined as communities that are more than 5 km or more than one hour's walk from a health facility.[24] The total number of pregnant women and children expected to benefit (nationwide and in the hard-to-reach areas) is shown in Table 1 based on census data for the country.[25] Cumulatively, approximately 1.4 million women and 1.1 million children will have access to improved health services, of which 20 percent are estimated to live in hard-to-reach areas.

Table 1. Total Number of Targeted Populations

Targeted populations	2016	2017	2018	2019	Cum. Total	%
Population (Total)	6 598 312	6 744 365	6 893 650	7 046 240		
Population >5km	1 319 662	1 348 873	1 378 730	1 409 248		
No. of pregnant women (Total)	330 279	337 589	345 062	352 700	1 365 629	
No. of pregnant women (>5km)	66 056	67 518	69 012	70 540	273 126	20%
No. of children 0-11 mos. (Total)	263 932	269 775	275 746	281 850	1 091 303	
No. of children 0-11 mos. (>5km)	52 786	53 955	55 149	56 370	218 261	20%

28. **Among essential health personnel, cadres at all levels will benefit from project support.** These different cadres are shown in Table 2.

[24] In addition to this definition of hard-to-reach areas, the district medical officer has the flexibility to designate areas requiring additional health services due to poor indicators as hard-to-reach areas. Sources estimate that about 20 percent of the population lives in hard-to-reach areas.

[25] The 2015 census may significantly change the number of direct beneficiaries once the results are published in 2016. The census will also affect those indicators in paragraph 30, which are expressed as a share of the population or specific subpopulation.

Table 2. Essential Health Personnel Targeted by the Project

Level	Cadre	Project Contribution
Community	CHWs	Training, supervision, logistics, incentives
District	MDCTs	Hospital and laboratory equipment
	Physician assistants	Curriculum development
	Midwives	Preservice training
	Public health aides	Training, supervision, logistics
	Ambulance paramedics and drivers	Recruitment, training, and supervision
	Doctors, midwives, and nurses	Continuing professional development
Region	Clinical specialists	Clinical residency program
	Specialists (MDCTs)	On-the-job capacity building

Note: MDCTs = Multidisciplinary clinical teams.

29. **The ministry's capacity to plan, coordinate, and monitor interventions in the health sector will be enhanced.** Support will be provided to 8 central-level directorates and all 14 DHMTs. The eight directorates are as follows: PHC; Reproductive and Child Health; Training; Hospital and Laboratory Services; Nursing Services; Health Systems, Policy, Planning, and Information; Environmental Health and Sanitation; and Financial Resources.

PDO Level Results Indicators

30. **Key outcome and intermediate outcome indicators have been selected to measure the achievement of the PDOs and component results.** As identified and defined in the Results Framework (annex 1), two outcome indicators will measure utilization and two will measure quality. The proposed outcome indicators are as follows:

- Utilization
    - Percentage of pregnant women attended four or more times by any health personnel
    - Percentage of births attended by skilled health personnel (doctors, midwives, nurses, MCH assistants)
- Quality
    - Percentage of pregnant women receiving tetanus toxoid (TT) two or more times
    - Percentage of children (0–11 months) fully vaccinated

31. In addition, the project will monitor several core sector indicators such as the number of direct project beneficiaries, including the proportion of female and the number of child (0–11 months) beneficiaries.

III. PROJECT DESCRIPTION

A. Project Components

32. To date, the Bank-financed EERP has provided support to Sierra Leone's post-Ebola recovery;[26] project restructuring is currently under way to (a) modify the PDO from response and mitigation to support for the country's post-Ebola health recovery efforts and (b) extend the project closing date to September 30, 2019. The restructuring of the EERP coincides with the preparation of the HSDSSP, which is designed to contribute to the flagship programs proposed by the Health Sector Recovery Plan; the PDO responds specifically to the second presidential priority for the health sector, the need to improve MCH outcomes.

33. As conceived, the EERP and HSDSSP will (a) share a common programmatic framework; (b) provide complementary financial inputs;[27] and (c) use the same fiduciary arrangements. Other implementation synergies with different development partners, and particularly with the proposed Regional Disease Surveillance Systems Enhancement Project (REDISSE), may also be possible.[28]

Component 1: Health Service Delivery (IDA US$7.3 million equivalent; ERRTF US$3.8 million)

34. Component 1 will contribute to improving service delivery and restoring the confidence of the project beneficiaries in the provision of public sector health care services. Two subcomponents are planned: (a) to strengthen community-level service delivery and (b) to enhance facility-level services and ensure emergency transport, especially for pregnant women, from communities and PHUs to the DHs.

Subcomponent 1: Community-Level Engagement

35. Drawing on the contributions of CHWs to the national response to the Ebola outbreak,[29] the MoHS has recognized their importance as key players for (a) improving community access to basic health care and information for mothers and children and (b) acting as change agents for increased community engagement and ownership of health service delivery. Community-level initiatives will be carried out under the project, including (a) the CHW Program and (b) the Environmental Health and Expanded Sanitary Inspection Compliance and Enforcement (ESICOME) Program.

[26] The EERP has provided support to Guinea, Liberia, and Sierra Leone. The original project in the amount of US$105 million was approved on September 16, 2014, and had an original closing date of September 30, 2015. Additional financing (US$285 million) was approved by the Bank in November 2014, and the closing date was extended to September, 30, 2016, with a plan to further extend until 2019.

[27] The EERP is expected to disburse the bulk of the remaining funds in 2016–2017, while the HSDSSP will provide continuing funds over 2016–2019.

[28] Annex 2 includes references to the contributions of the other partners, and annex 6 summarizes these contributions in a table.

[29] CHWs played key roles in four areas: (a) community event-based surveillance and Ebola virus disease (EVD) alerts (with more than 95,000 between December 2014 and May 2015); (b) contact tracing; (c) participation in safe burial teams; and (d) behavior change (handwashing, early care seeking, and so on).

36. **Community outreach (CHW Program) and engagement.** The MoHS is currently revising the CHW policy adopted in 2012.[30] The revised policy focuses on (a) strengthening a cadre of health personnel, recognized by the community, selected on the basis of specific criteria, and trained to deliver a minimum package of health services and (b) providing these services to hard-to-reach areas, defined as communities that are more than 5 km or more than one hour's walk from a health facility.[31] Among others, the revised policy aims to (a) establish a feasible ratio of CHWs to the population (currently estimated by the MoHS at 1 CHW per 100–500 persons); (b) provide more intensive initial training; (c) ensure adequate supplies and supportive supervision; and (d) incentivize the work with a motivation package including financial and nonfinancial incentives.[32] Nonfinancial incentives include badges/identification cards, T-shirts, backpacks, torchlights, pens, pencils, erasers, notebooks, soap, and rain gear, all aimed at facilitating delivery of services in the community. In addition to the Bank, UNICEF, the Global Fund, DFID, and USAID are contributing to the program, as well as numerous NGOs and technical partners.

37. The MoHS estimates that about 15,000 CHWs will be required to cover the country and that about 5,000 will be needed to cover the hard-to-reach areas. The HSDSSP will finance (a) financial and nonfinancial incentives for those 5,000 CHWs for the hard-to-reach areas; (b) routine supervision costs for the peer supervisors and the chiefdom supervisors for these CHWs; and (c) overall coordination and evaluation of the program.

38. Community engagement will be a core principle of the CHW initiative: (a) communities will be involved in the selection and annual assessment of the CHWs' performance and (b) existing community structures, such as the village development committee (VDC) and the facility management committee (FMC) of the local PHU, will enhance accountability for the health services delivered to the population. To strengthen community engagement, the project will finance (a) development of appropriate tools for community assessment of the availability and quality of services at the community level; (b) periodic discussion of CHW performance with community members, relevant local authorities, and health staff; and (c) feedback of the results of these discussions to district and national officials.

39. **Environmental Health and Sanitation (ESICOME Program)**. Consistent with the current legislation, LCs (and other local-level structures) have a clear mandate for the implementation of premises inspection, and the MoHS provides strategic direction and support to enable councils to perform their roles effectively. With the adoption of the ESICOME Program, the MoHS will rely on a combination of sustained public health education and enforcement of sanitary regulations where behavioral change and communication strategies are not successful.

40. To strengthen the regulatory framework, the HSDSSP will finance technical assistance and support for (a) completion of the National Environmental Health and Sanitation Policy and

[30] Before 2012, CHW programs in the country had been fragmented and vertical and overseen and implemented by different ministry directorates and NGOs.

[31] The policy also affords flexibility to the DHMTs to identify areas that are not considered hard to reach according to this definition but may require additional health services due to poor indicators.

[32] International evidence as well as studies from Sierra Leone suggest that incentives and regular supervision are essential for ensuring high-quality work and retention of CHWs. See also Sarah Adomakoh, Addressing CHW's Motivations, Performance, and Retention in a Fragile or Resource Poor Setting (Save the Children, 2014).

Strategy; (b) revision and update of the Public Health Ordinance (1960),[33] (c) dissemination of the policy, strategy, and regulatory guidelines; and (d) implementation of the standard operating procedures.

41. Premises inspection has been routinely (but haphazardly) carried out by public health aides (PHA) under the direction of public health inspectors (PHIs). The HSDSSP will finance the professionalization of this cadre of PHAs by providing (a) training of 400 PHAs (to be conducted in Freetown, Bo, and Makeni); (b) equipment (especially personal identity cards, uniforms, start-up kits, personal protective equipment, and so on); and (c) routine operational expenses (materials, transport, supervision, and so on) to implement the initiative nationally.

Subcomponent 2: Facility-Level Service Strengthening

42. Based on the need to establish high-quality health services at the PHU and DH levels and to ensure emergency transport from the PHU to the DH when necessary, the project will finance measures to strengthen PHUs' and DHs' ability to deliver quality high-impact services (especially for MCH conditions) and to organize emergency transport through the establishment of a national ambulance service.

43. **Multi-Disciplinary Clinical Teams (MDCTs).** With the end of the Ebola crisis, the MoHS has shifted its focus from (a) foreign medical teams (FMTs) to MDCTs and (b) epidemic response to comprehensive health service delivery, with a particular emphasis on maternal, newborn, and child health services. Because Sierra Leone expects the return of a significant number of medical doctors over the next 12–18, months, the MDCTs will provide crucially needed services over that period.

44. Under the component, 43 medical doctors, 4 radiographers, 4 laboratory technicians, 23 midwives, and 23 nurses will be recruited and deployed among 22 government hospitals located throughout the country. The MDCTs will provide (a) direct service delivery in the hospitals in which they are deployed, thus increasing the number of available medical specialists and (b) capacity building and skills transfer through in-service training and on-the-job coaching and mentoring of national staff counterparts who are already serving in the same public hospitals. In addition to supporting the MDCTs, the project will also finance the procurement of hospital equipment and supplies.

45. **Emergency medical services.** As a part of the Ebola response, more than a hundred ambulances were procured by or donated to the government to facilitate the transfer of suspected EVD cases to Ebola treatment centers. Capitalizing on these investments and with initial support from the ongoing EERP, this component will support the establishment of emergency medical services (EMS) to improve service delivery, especially for emergency obstetric care. The full details of the EMS system (for example, management structures, staffing and training, financing

[33] The current Public Health Ordinance, dating from 1960, was clearly demonstrated to be obsolete during the Ebola epidemic.

and sustainability, and so on) will be developed by consultants, based on principles established by the MoHS.[34] The HSDSSP will finance initial training for up to 165 drivers and 500 paramedics.[35]

Component 2: Health System Support (IDA US$2.7 million equivalent; ERRTF US$1.7 million)

46. Component 2 will contribute to the development of health human resources and sector management and coordination. Three subcomponents are planned to (a) develop critical cadres of health human resources to strengthen service delivery at the PHU and DH levels; (b) improve the oversight and management performance of the MoHS at the central and district levels; and (c) ensure effective project management and M&E.

Subcomponent 1: Health Human Resource Development

47. The component will develop two complementary cadres of staff for deployment to PHUs and DHs: (a) specialists in the areas of obstetrics/gynecology, pediatrics, surgery, and family and internal medicine and (b) physician assistants, nurses, and midwives with skills to enhance the quality and efficiency of service delivery.

48. **Clinical residency training.** Under this subcomponent, local specialist training will be established through the Sierra Leone Council for Post-Graduate Colleges of Health Specialties (SLCPGCHS) and the Teaching Hospital Complex Administration (THCA).[36] By authorizing the local training of specialists, the legislation will increase the number of specialized staff able to provide high-quality tertiary care and accelerate the pace of skills transfer to junior medical officers. The HSDSSP will finance (a) recruitment of consultant trainers; (b) stipends for clinical resident specialists in surgery, pediatrics, obstetrics and gynecology, internal medicine, and family medicine; and (c) program coordination costs.

49. **Auxiliary health worker training (Makeni).** Training is envisioned for two cadres of mid-level health staff: (a) clinical health officers (CHOs), who will be trained as physician assistants to permit task shifting from medical officers in the DHs and (b) midwives, who will provide a critical link with the PHC system, conducting capacity building, coaching, and mentoring for staff in PHUs with an emphasis on improving quality of care as well as early detection and referral of patients requiring services provided by the MDCTs at the district level.

50. For the CHO training, the HSDSSP will finance (a) acquisition of dormitory, classroom, and laboratory materials and (b) development of the curricula, pedagogical materials, and books. For the midwives training, the HSDSSP will finance graduate midwifery training courses for nurses in Freetown (18 months) and Makeni (24 months), including stipends while they are on

[34] The MoHS has determined that ambulance services will (a) be regulated by a National Ambulance Commission; (b) be stationed at regional hospitals and national fire force stations; (c) be expected to provide full geographic coverage across the territory of Sierra Leone (rather than implementing in one region first and then expanding to other regions over time); and (d) increase the density of EMS teams as time, resources, and demand permit/require. In addition, the MoHS intends to contract the management of the ambulance service to the private sector.

[35] Paramedic training will be equivalent to that of Basic Life Support (BLS) training, with an expected 4–6 weeks training program using a standard curriculum. Ambulance teams will consist of two paramedics, including a driver, and teams will be available 24/7.

[36] The parliament enacted the SLCPGCHS Act on February 4, 2016 and the THCA Act on March 3.

training to cover logistics and other incidentals. The HSDSSP will also contribute to the establishment and implementation of a continuing professional development (CPD) program for medical doctors, nurses, and midwives. The program is currently being piloted in a hospital in Freetown with support from the WHO. The HSDSSP will finance the rollout and supervision nationwide.

Subcomponent 2: Sector Coordination and Management

51. Project interventions will support the central- and district-level activities.

52. **Support to MoHS directorates.** The HSDSSP will support technical assistance with oversight by the offices of the Chief Medical Officer (CMO) and Chief Nursing Officer (CNO) to support the top management staff and the eight directorates of the MoHS. In addition, the project will support the Directorate of Reproductive and Child Health (DRCH) in implementing the Maternal Death Surveillance and Response (MDSR) initiative by financing (a) quarterly reviews of the results of the district investigations of suspicious maternal deaths and (b) a maternal death response fund. The Directorate of Health Systems, Policy, Planning, and Information (DPI) will benefit from capacity established under the RCHP2 and continue to receive support for (a) planning and supervision (annual district planning support, quarterly supportive supervision, annual district reviews); (b) M&E (HMIS development, publication of the quarterly HMIS bulletin); (c) organization of special sector studies (national health accounts, health sector financing strategy, and so on); and (d) operational costs.

53. **Support to the DHMTs.** The DHMTs are the primary implementers of the Basic Package of Essential Health Services (BPEHS) and the National Health Sector Strategic Plan (NHSSP). As such, they are responsible for planning, implementing, and monitoring health service provision; their tasks include supplying equipment and drugs to health facilities within the district; staff training and supervision; data collection from PHUs and reporting to the national level; community engagement; and ensuring that quality and equitable health services reach the population within the district. The HSDSSP will support the implementation of the MDSR by financing (a) investigations of the causes of suspected maternal death both in the communities and in the health facilities and (b) quarterly reviews of the results of the investigations.

54. **Service-level agreement.** Launched by the president of Sierra Leone in July 2015, service-level agreements (SLAs) are intended to improve coordination and accountability of donor-supported efforts at the district level. Negotiated and signed by the implementing partners (IPs) and health authorities at the central, district, and local levels, SLAs are intended to ensure the consistency of planned interventions with the MoHS' priorities, improve coordination between the MoHS and its IPs, and hold IPs accountable for results of their activities. The SLAs are subject to regular monitoring through (a) quarterly reports submitted by the IP to the MoHS and (b) semiannual joint monitoring visits involving the MoHS, the IP, districts, and the donor. To strengthen the SLA initiative, the HSDSSP will finance (a) routine supervision costs; (b) semiannual consultations with IPs and development partners; and (c) publication of quarterly updates.

Subcomponent 3: Project Management, Monitoring and Evaluation

55. To enhance the organization and management of the MoHS, the Bank (through the RCHP2 and EERP) and other development partners (Global Fund and Global Alliance for Vaccine Initiative [GAVI]) have supported the establishment of the Integrated Health Project Administration Unit (IHPAU). The IHPAU is intended to provide oversight of all externally financed projects with a view to improving their planning, implementation, and monitoring. From 2016, financing of the IHPAU will be shared proportionally by the participating partners, currently the Bank (RCHPs and the EERP and prospectively the HSDSSP); Global Fund for AIDS, TB, Malaria; GAVI; and AfDB and potentially by others partners.

Component 3: Contingency Emergency Response (US$0)

56. Sierra Leone has been declared free of Ebola but is currently in a phase of enhanced surveillance to quickly detect any resurgent cases and prevent further spread. Given the moderate to high risk, during the life of this project, that another outbreak of EVD or other major epidemic may occur and have adverse social and economic impact, this component aims to improve the government's response capacity in the event of an emergency, following the procedures governed by paragraph 13 of OP 10.00 (the Contingent Emergency Response (CRM) component under Investment Project Financing). In anticipation of such an event, this emergency component provides for a request from the country to the Bank to support mitigation, response, and recovery in the district(s) affected by such an epidemic.

B. Project Financing

57. **The proposed lending instrument is Investment Project Financing.** The US$15.5 million equivalent cost of the project will be financed by an IDA credit of US$10 million equivalent and an ERRTF grant of US$5.5 million. The project will be implemented over a 3-year period. The HSDSSP IDA financing across the two components (65 percent for Component 1 and 61 percent for Component 2) is complementary to the EERP financing across the two components.

Project Cost and Financing

58. Table 3 summarizes the project's costs by component and source of financing.

Table 3. Project Costs by Component (US$, millions)

Component/Subcomponent	Project Cost	IDA	ERRTF	% IDA
Component 1: Health Service Delivery	**11.1**	**7.3**	**3.8**	**65**
Subcomponent 1: Community-Level Engagement				
Community outreach	6.3	6.3	0.0	
Environmental health	0.5	0.5	0.0	
Subcomponent 2: Facility-Level Service Strengthening				
MDCTs	3.8	0.0	3.8	
EMS	0.5	0.5	0.0	

Component/Subcomponent	Project Cost	IDA	ERRTF	% IDA
Component 2: Health System Support	**4.4**	**2.7**	**1.7**	**61**
Subcomponent 1: Health Human Resource Development				
Clinical residency training	0.4	0.4	0.0	
Auxiliary health officer training	2.4	0.7	1.7	
Subcomponent 2: Sector Coordination and Management				
Support to MoHS directorates	0.2	0.2	0.0	
Support to DHMTs	1.0	1.0	0.0	
SLA	0.2	0.2	0.0	
Subcomponent 3: Project Management, Monitoring and Evaluation				
IHPAU	0.2	0.2	0.0	
TOTAL	**15.5**	**10.0**	**5.5**	**65**

C. Lessons Learned and Reflected in the Project Design

59. The response to the devastating EVD epidemic has reminded health authorities of the importance of specific aspects of health service delivery and system support.

60. First, the EVD experience has demonstrated that community confidence is an essential element of the demand for health care services. As shown earlier, though virtually all of the PHUs remained open during the epidemic, utilization declined precipitously due to the community's fear of contracting the virus and lack of confidence in the services offered. Where, however, communities were fully engaged and active in the EVD response (in contact tracing, surveillance, and so on), the response was more effective. Consequently, while the project will intervene at all levels of the system, it will focus on reengaging with the community, restoring the public's confidence in the efficacy of the essential package of basic health services, and strengthening the quality of service delivery by CHWs and PHUs.

61. Second, the tragic loss of health care workers to Ebola exacerbated the extreme lack of skilled health care workers in the country. As shown earlier, the project will address a wide range of essential health cadres by financing preservice, in-service, and refresher training. For training to succeed, it must be guided by the need to shift competencies and tasks to lower-level cadres who are more likely to be present and remain in remote areas to deliver services.[37] The human resource for health development will thus emphasize decentralized training, practical skills development, and effective supervision and accountability arrangements. In addition, the project will make adequate equipment and supplies available to ensure quality service delivery.

62. Third, the MoHS believes that the massive influx of funding in response to the epidemic provides a second and perhaps final opportunity (after the experience following the end of the civil war) to substantially rebuild the health sector in a sustainable manner. To capitalize on this situation, the MoHS intends to play an active role in managing planning and sector coordination and envisions multiple instruments, including (a) local specialist training capabilities within the

[37] Key examples of cadres who will benefit from task shifting include the CHW at the community level, the MCH aides at the PHU level, and the physician assistants at the DH level.

system of higher education; (b) EMS through a management contract; and (c) donor coordination through the use of SLAs.

63. Fourth, based on the experience of the Integrated Project Administrative Unit (IPAU) established by the Ministry of Finance and Economic Development (MoFED) to manage donor-financed projects, the MoHS has established a similar entity for the health sector. Jointly financed by the Bank (through the RCHP2 and EERP), the Global Fund, and GAVI, the IHPAU will provide the necessary fiduciary oversight of all externally financed projects including this one.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

64. **Recovery planning is coordinated centrally by the Presidential Delivery Unit and the sectoral ministries.** For the health sector, the Minister of Health oversees the planning process and implementation of the recovery phase of the ministry's Post-Ebola Health Sector Recovery Plan (2015–2020). The minister is supported by a dedicated delivery unit headed by the CMO and in collaboration with the health sector coordinating committee (HSCC) and the flagship forum. The HSCC is chaired by the minister and includes the heads of agencies of development partners supporting the health sector.

65. The flagship forum was established to take stock of progress in reaching the milestones for each of the flagship programs under the 10–24-Month Recovery Plan. The forum comprises the minister and deputy ministers, the CMO and the two deputy CMOs, the CNO, and the directors of the directorates responsible for the flagship programs supported by the project.

66. **The project will be implemented by the MoHS under the leadership of the Project Steering Committee.** The Steering Committee will provide overall technical guidance and oversight for the project and will comprise (a) the CMO, who will serve as project director and provide overall project management and (b) the directors of the eight directorates involved in project implementation. The CMO will work closely with the MoFED and local government authorities at the central and district levels to ensure cohesion between the planned flagship initiatives and their district implementation.

67. Each of the subcomponents has been designed with and will be implemented by the relevant MoHS directorate and the DHMT, which will have technical responsibility for the results. A more detailed description of the arrangements by subcomponent is presented in annex 3. The IHPAU will provide fiduciary support to the proposed project as well as to other donor-supported projects in the health sector. IHPAU specialists will comprise fund management; financial management (FM); procurement; audit specialist; and M&E, accountability, and learning.

68. The MoHS will prepare a Project Implementation Manual (PIM), which will be approved by the Bank before project effectiveness. Each year, not later than November 30, the project will prepare an annual program of activities proposed for implementation under the project during the following calendar year. This annual work plan, together with a proposed budget, will be submitted for approval to the Bank. Requirements for procurement planning, quarterly financial reports, annual reports, and annual audits are addressed in the Appraisal Summary section and in annex 3.

B. Results Monitoring and Evaluation

69. **The PDO indicators and key intermediate outcome indicators were agreed with the MoHS and its development partners.** By aligning the indicators used by the MoHS and its partners, the project aims to increase ownership of the selected indicators and strengthen the existing (and proposed) M&E systems. Selection of the indicators was based on a consideration of (a) the project's three-year duration; (b) the proposed subcomponent support; and (c) the availability of data (for baselines and regular monitoring). The Results Framework and M&E arrangements are described in annex 1.

70. **The outcome indicators were selected from available data sources and used results from 2013 as the baseline.** This is because (a) these data constitute the last full year for results before the Ebola outbreak and (b) it is possible to compare Demographic and Health Survey (DHS) results with those of the national health management information system (HMIS). The intermediate outcome indicators also rely on data which are expected to be regularly available from (a) CHW Program monitoring; (b) public health checklists for the PHAs; (c) the biannual facility improvement team assessments and scorecards (for emergency obstetric and newborn care); (d) the national ambulance service data; (e) training program information; and (f) Planning Directorate information (SLA, annual reviews, and so on). Where baselines have not been provided, they will be established during the initial six months of the project as the indicators are rolled out and data become available.[38]

71. Given the Bank guidelines requiring inclusion of a citizen engagement (CE) indicator in the Results Framework, several alternatives were considered and an indicator was selected in collaboration with the MoHS. A discussion of this CE indicator is presented in annex 7.

72. **The DPI and IHPAU will be responsible for producing regular reports on the results.** The Planning Directorate is responsible for the HMIS data and will ensure that the results are collected regularly by health facilities, submitted in a complete and timely manner to districts, and aggregated nationally by the directorate. The IHPAU will work closely with the Directorate of Financial Resources and DPI to prepare comprehensive financial and program information. Financial data are expected to be available within 45 days of the completion of the funding period while program information is expected to be available within 90 days of the end of each quarter.

73. The project will support efforts to improve data collection and analysis at the central, district, and community levels. In addition, resources are available for selected studies and evaluations. The project will support (a) annual program reviews and (b) annual district planning exercises, which will enable the central and district levels to analyze experience and incorporate the results into future plans.

C. Sustainability

74. **A framework exists for successful implementation of the project's components and future maintenance of the project's benefits.** Within the context of legislation establishing the responsibilities between the central and district levels, existing documents provide a basis for

[38] A national census has been conducted, several national surveys (including the Integrated Household Survey and the Multi-Indicator Cluster Survey) are planned for 2016, and HMIS results for 2015 are expected by June 2016.

action. These include (a) overarching frameworks (for example, the National Health Sector Strategic Plan, the BPEHS, the FHCI); (b) comprehensive plans (for example, the Health Sector Recovery Plan); and (c) key program documents (for example, the Reproductive, Neonatal, and Child Health Strategy). Additional planned measures include, among others, a revised CHW policy, an updated Health Human Resources Plan, and important legislative and regulatory measures, some of which have been recently passed to guide the clinical residency programs and others, which will be presented to the parliament during implementation, such as the Public Health Ordinance and the National Ambulance Commission.

75. **The project will support proven strategies to improve the health situation in the short term and contribute to more sustainable systemic solutions in the long term.** The project will focus on community and health facility levels and on specific measures that have had demonstrably successful results in reducing maternal death and improving child health.[39] At the community level, these measures include (a) the integration of trained and supervised health care providers and (b) the promotion among the population of both knowledge of and incentives to adopt healthier behavior.[40] At the facility level, the measures will address the professionalization of services (attendance, hygiene, and so on) and in particular health worker attitudes toward patients. Finally, measures will be introduced to ensure the timely transfer to higher-level facilities for emergency interventions. Combined, these measures should be sustainable and have a positive impact on the reduction of maternal and child death.

76. **The project will address but cannot on its own resolve the principal issues related to health system sustainability.** First, the project's human resource interventions will address both the number and quality of health cadres and broader systemic issues by (a) simultaneously recruiting and training staff locally (from CHWs to nurses, midwives, and physician assistants to clinical residents); (b) emphasizing practical competencies and task shifting; and (c) strengthening supportive supervision. These measures do not resolve the issue of health worker remuneration, career development, and so on, but they should contribute positively to the distribution, capabilities, and attitudes of staff.

77. Second, because current levels of international support to Sierra Leone are clearly not sustainable, the project will (a) contribute to a continuing analysis of health sector financing (for example, national health accounts, the Health Financing Unit within the MoHS, and so on) and (b) initiate early analysis of exit strategies for project-financed strategies, which may prove to be costliest (for example, the CHW Program, EMS, and HR training). For example, the project has made disbursement for the Bank-financed CHWs contingent on approval of this cadre by the government's Human Resources Management Office, the Public Service Commission, and the MoFED. Thus, although the project alone is unlikely to resolve the financing and fiscal space issues over the project's short duration, it should help the government assess the situation more comprehensively and explore evidence-based options for addressing these issues.

[39] ODI (Overseas Development Institute). 2012. "Delivering Maternal Health: Why Is Rwanda Doing Better than Malawi, Niger, and Uganda?" Briefing Paper No. 74.

[40] The environmental health subcomponent will use a combination of public education and fines, which may be adaptable for antenatal care and assisted delivery.

V. KEY RISKS

Table 4. Risk Ratings Summary Table

Risk Category	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
OVERALL	**Substantial**

A. Overall Risk Rating and Explanation of Key Risks

78. The overall risk of the proposed operation is rated as **Substantial**, due in large measure to the macroeconomic situation, technical design of the project, institutional capacity for implementation and sustainability, and fiduciary risks. The operation has also been screened for short and long term climate change and disaster risks. On the macroeconomic risk, the health sector has historically demonstrated an ability to deliver services, even in the face of national threats (civil war, Ebola epidemic, climate change, and disaster risks), systemic weaknesses, and insufficient resources. However, the combined economic aftershocks of the Ebola epidemic (and the potential for a future outbreak) and the estimated needs (organizational, financial, technical, and so on) for health sector recovery constitute enormous challenges for the country. Mitigating these substantial risks are the sustained political backing by the government and partners, financial resources from partners, and technical support provided by the country's development partners/stakeholders including the Bank.

79. On the technical design of the project, while the proposed components are broad and complex, they build on national policies and plans that have been formulated by the government in collaboration with development partners and are based on global experiences and evidence. Operationalizing these initiatives has been challenging even before the advent of the Ebola epidemic; for this reason, rather than the promotion of new initiatives, this project will focus on the implementation of proven measures accompanied by implementation support and technical assistance from the Bank and other technical development partners.

80. To address the institutional capacity constraints, the project has identified a series of immediate measures to increase the utilization and quality of health services while establishing the longer-term basis for strengthening health human resources and improving the quality of health service delivery. In the short term, the project will build on existing efforts to (a) enhance decentralization and the involvement of the LCs and communities; (b) strengthen the role of DHMTs; and (c) improve coordination between the MoHS and its IPs and hold IPs accountable

for results through the development of SLAs. In the longer term, project support for human resource development elements will follow on the recent approval of legislative and regulatory measures by the government. Sustainability of the project achievements remains an issue in light of the negligible immediate fiscal impact that will require ongoing Bank, IMF and other partners' engagement to address the macroeconomic challenges faced by the government.

81. As a result of previous experience with Bank projects and especially with Ebola, risk related to fiduciary is rated Substantial and mitigating measures including agreed action plans are discussed in details in the fiduciary sections (procurement and financial management) and include capacity building, technical assistance, enhancing the revenue management framework, and strengthening internal control mechanisms over procurement, disbursement and accountability of funds for eligible expenditures. Environmental issues (particularly sanitation, medical waste management, climate change, and disaster risks) are rated Moderate.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

82. **Coming in the aftermath of the Ebola crisis, the importance of investing in strengthened health systems is immediately apparent.** First, with its immediate disruption of lives, livelihoods, and businesses, the linkage between health and macroeconomic performance has been clearly demonstrated. Second, the response to the epidemic has confirmed the importance of public health sector investment on (a) high-impact and cost-effective interventions to produce important positive externalities with limited resources and (b) financial risk protection afforded to those who might otherwise have faced extreme economic hardship as a result of ill health. Third, public investment in the health of the poor, particularly women and children, has been shown to contribute to economic and social growth and development and constitutes a prerequisite for reducing poverty.

83. Public interventions are usually justified, from an economic perspective, under two conditions: (a) the first one is that there are proved market failures and (b) the second is that interventions that could correct these failures without imposing additional costs on the taxpayers exist. These conditions are met in Sierra Leone. With an increased coverage of mothers and children, as well as a better quality of services provided to this target population, major savings in health expenditures can be expected in the near, mid, and long term.

84. **Two complementary analyses of the project's costs and benefits have been carried out.** Because the project emphasizes both health services delivery and health systems support, two analyses were conducted (including EERP and HSDSSP costs and benefits); the results are presented in annex 5. First, an estimate of the costs and benefits generated by the project's CHW approach examines the project's investments directly affecting MCH interventions.[41] Costs have been estimated for the period 2016–19 (project is expected to last 3 years) and benefits for the CHW component are estimated for the period 2016–2020, under the minimal assumption that the program will continue to operate for one more year after the project closure. The main direct benefit derives from the economic value of lives saved and the cost savings for reduced risk factors

[41] These include the following subcomponents financed by both the EERP and HSDSSP: CHW, MCDT, EMS, clinical residency training, and auxiliary health worker training.

for communicable diseases (mostly) and non-communicable diseases (NCDs). Because of scarcity of data relating to disability-adjusted life years (DALYs), the Lives Saved Tool (LiST)[42] is used to estimate the number of lives saved due to changes in coverage of reproductive, maternal, neonatal, and child health interventions in the selected districts. In Sierra Leone, the CHW Program could save 16.35 lives per 100,000, or a total of 503 lives over the period 2016–2020. Translated into life years saved (LYS) and valuing a life year on gross national income per capita, the analysis shows (a) a benefit-cost ratio (BCR) of 1.50 and (b) an internal rate of return (IRR) of 15.58 percent. Both the BCR and the IRR validate the decision to implement the CHW Program on MCH in Sierra Leone.

85. Second, the analysis estimates the costs and benefits of the project as a whole. Estimates are based on project costs for the period 2016–19, project benefits for the period 2016–20, and DALYs averted as the main direct benefit resulting from the increased utilization and improved quality of essential MCH services in the selected districts. Estimating DALYs lost by mothers and children in Sierra Leone at 3,389,000, or 629 DALYs per 1,000 persons, the analysis shows (a) a BCR of 1.33 and (b) an IRR of 11.47 percent. Both the BCR and the IRR validate the decision to implement the HSDSSP in Sierra Leone.

86. **The immediate fiscal impact for the country is negligible.** Bank financing will be through (a) an IDA credit of US$10 million equivalent; (b) a grant of US$5.5 million as part of the Ebola Emergency Trust Fund; and (c) the undisbursed EERP funds of approximately US$27 million.[43] The government of Sierra Leone (GoSL) financing for this project is negligible. The project being strategically focused as it supports activities that will reduce public health expenditures on the mother and child in the future, the mid- and long-term fiscal impact should be positive.

87. **Project sustainability may be an issue.** The immediate fiscal impact for the country is negligible, and the project's contribution to reducing future public health expenditures on the mother and child should yield positive mid- and long-term fiscal impacts. After 2019, the GoSL will have to essentially finance in-service training, pay incentives to the CHW, maintain the acquired equipment to preserve MCH coverage levels, and cover emergency MCH transportation needs. This can be estimated at an annual contribution of about US$4.55 million or US$0.70 per capita. However, with a very low public spending per capita of about US$6.5 (despite the WHO's most recent recommendation of US$54) and despite the low cost of pursuing the project after 2018, project sustainability might be an issue.

B. Technical

88. **An overarching framework for health sector development existed before the EVD crisis and remains relevant for the proposed project.** The government's Agenda for Prosperity and the MoHS' Health Sector Recovery Plan comprise (a) specific policy directives (for example, the BPEHS, the FHCI); (b) program approaches (for example, CHW, RNCH, MDSR); and (c) sector management orientations (for example, the National Health Compact, Results, and

[42] The Lives Saved Tool, Johns Hopkins, Bloomberg School of Public Health. The Lives Saved Tool models the impact of scaling up the coverage of proven interventions on maternal, neonatal, and child mortality by integrating evidence on intervention effectiveness and demographic projections of mortality.
[43] Undisbursed funds from the EERP have been estimated at US$27 million on February 15, 2016.

Accountability Framework). Though slowed by the Ebola epidemic, these initiatives constitute a solid basis for the implementation of the new project.

89. **The current policy and program orientations have demonstrated the soundness of the ministry's approach to improving maternal health services.** Within the context of the FHCI, the project will support the delivery of a BPEHS at the primary and first referral levels. As shown in table 5, the introduction of free health care and essential health services since 2010 has had a positive impact not only on the overall utilization of maternal health services but also on the equitable delivery of these services. All of the selected indicators have improved, and the differentials between the highest and lowest quintiles have almost uniformly declined.

Table 5. Maternal Health Indicators by Income Quintiles

	2008				2013			
Maternal health indicators	Overall	Richest	Poorest	Dif.	Overall	Richest	Poorest	Dif.
% of pregnant women receiving antenatal care from a skilled provider	86.9%	96.1%	82.1%	14.0%	97.1%	98.3%	96.0%	2.3%
% of pregnant women receiving 2+ TT	74.5%	84.3%	69.1%	15.2%	86.9%	85.7%	88.4%	-2.7%
% of births delivered in a health facility	24.6%	39.3%	16.9%	22.4%	54.4%	70.1%	48.4%	21.7%
% of births attended by skilled health personnel	42.4%	71.4%	28.1%	43.3%	59.7%	83.7%	50.9%	32.8%
% of mothers who received a postnatal care visit within 48 hours of childbirth	57.5%	74.4%	47.1%	27.3%	72.7%	76.4%	67.7%	8.7%

90. **The proposed project reflects the current consensus on priority needs in the post-Ebola context.** In the short term, the project will focus on (a) strengthening services and restoring confidence (particularly in MCH services) at the community and PHU levels of the health system and (b) improving linkages between primary and first referral health care services. In the longer term, the emphasis will be on systems strengthening, especially health human resource development and sector management and coordination. Given the insufficient capacity to simultaneously address health service delivery and systems strengthening, the project will finance technical assistance in several different formats: individual consultants, MDCTs, and management contracts.

C. Financial Management

91. The Bank conducted a limited FM assessment to determine the adequacy of the proposed FM systems of the IHPAU of the MoHS that is yet to be adequately staffed and fully operational. The assessment concluded that the proposed FM systems of the IHPAU of the MoHS meet the Bank's minimum requirements for the administration of projects funds under OP/BP 10.00. A comprehensive FM assessment of the IHPAU of the MoHS will be undertaken when the unit is fully staffed and the respective systems established and fully operational.

92. The IHPAU is headed by a fund management specialist/team lead who is responsible for ensuring the overall direction of work at the unit. Under the direction and supervision of the fund management specialist/team lead, the entire IHPAU accounting team that will comprise the finance

specialist (a qualified accountant), two accountants, and a finance assistant will be responsible for all the day-to-day FM functions of all the projects in the health sector in Sierra Leone.

93. The IHPAU's proposed budgeting, accounting, internal controls funds flow, financial reporting, and external audit processes will support the effective and efficient utilization of resources for the proposed project. The additional staff members will be recruited before project effectiveness to ensure that they are appropriately trained and ensure ample readiness to commence the project's implementation as soon as it becomes effective. The related operational costs of maintaining the staff during the life of the project, including computer hardware, stationery, mailing withdrawal applications, and printing project FM reports, will form part of the costs that the project shall bear as part of project management costs.

94. The IHPAU will open a U.S. dollar-denominated designated account (DA) at a commercial bank approved by the Bank. The project will initially use transaction-based disbursement against full documentation (statement of expenditure) and in line with the threshold as stated in the disbursement letter. Upon a sustained satisfactory FM rating during implementation, the project may move from transaction-based to report-based (interim financial reports [IFRs]) disbursement.

95. The project will follow a cash basis of accounting and financial reporting and will submit, within 45 days of each GoSL fiscal quarter, quarterly IFRs of the project activities. At a minimum, the constituents of the IFRs will be (a) a statement of sources and uses of funds for the reported quarter and cumulative period from project inception, reconciled to opening and closing bank balances; (b) a statement of uses of funds (expenditures) by project activity/component, comparing actual expenditures against budget, with explanations for significant variances for both the quarter and cumulative period; and (c) the DA reconciliation statement.

96. The annual audited financial statements of the project shall be submitted to IDA within 6 months of the end of the GoSL's fiscal year (that is, by June 30 each year). The external auditors will conduct the audits on the project financial statements on terms of reference (TOR) as will be agreed with the Bank within two months of project effectiveness.

97. **The overall FM risks were rated as High before mitigation, but with the planned risk mitigation measures if properly implemented, the residual FM risk is rated as Substantial**. A detailed description of the FM assessment is included in annex 3.

D. Procurement

98. **Procurement will be managed within the context of the Public Procurement Act, which incorporates many features that meet international best practices in public procurement.** The National Public Procurement Authority (NPPA) was created to manage the public procurement function, and it has significantly advanced the reform of the national public procurement system, for example, by creating regulations, standard bidding documents (SBDs) and requests for proposals, and user manuals to implement the project preparation advance (PPA).

99. **Procurement under the project will be carried out in accordance with Bank procedures.** These include (a) 'Guidelines: Procurement of Goods, Works, and Non-Consulting Services Under IBRD Loans and IDA Credits & Grants by World Bank Borrowers', dated January 2011 and revised in July 2014; (b) 'Guidelines: Selection and Employment of Consultants Under

IBRD Loans and IDA Credits & Grants by World Bank Borrowers', dated January 2011 and revised in July 2014; (c) 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants', dated October 15, 2006, and revised in January, 2011; and (d) the provisions methods stipulated in the Financing Agreement.

100. Health sector procurement should be managed by the National Pharmaceutical Procurement Unit (NPPU), the Directorate of Support Services (DSS), and Directorate of Drugs and Medical Supplies (DDMS). The NPPU, together with the DDMS, should be responsible for procuring, storing, and distributing all drugs and medical supplies to all public health facilities throughout the country. The NPPU is currently undergoing review by the government and is therefore unable to perform this role. The IHPAU will be responsible for all procurement under the project and will do so working closely with the DSS and DDMS providing the required technical inputs. As needed, the Government may also directly contract relevant UN Agencies for procurement services.

101. **The procurement risk is considered to be Substantial for several reasons.** First, as the IHPAU is currently being established, it has limited capacity to handle the project procurement activities; staff are few and lack necessary qualifications and experience and there is a risk that the required procurement skills will not be found during the recruitment process. Second, an organizational structure and mechanisms for evaluating tenders, awarding contracts, and managing execution and payment are not sufficiently developed.

102. As risk mitigation measures, capacity building will be required for the procurement team on the Bank procurement procedures, and technical assistance (TA) will be recruited to assist the procurement team until it is able to handle procurement processes. Procurement internal control mechanisms in line with the NPPA regulations will be established and should include at least a procurement unit, an evaluation committee, and a review committee (including the minister and permanent secretary from the MoHS and the MoFED representative), on large tenders above a threshold that will be discussed and agreed upon. The MoHS will set up an ad hoc technical evaluation committee composed of subject matter specialists drawn from the ministry and IHPAU who will be responsible for evaluation of tenders and recommendation of award. The technical evaluation committee may seek assistance from a specialist in evaluation of tenders where they do not have required technical skills. The MoHS will establish a procurement committee within the IHPAU for a specific period, with a mandate of reviewing evaluation and making recommendations of award to management.

E. Social (including Safeguards)

103. **The project will not have a negative social impact.** The project will not finance any activities necessitating land acquisition and resulting in (a) the involuntary resettlement of people and/or loss of (or access to) assets, means of livelihoods, or resources or (b) the involuntary restriction of access to legally designated parks and protected areas, resulting in adverse impacts on the livelihoods of the displaced persons.

104. Rather, the project will have a positive social impact on communities and on particular groups in these communities: (a) communities will benefit from the recruitment of CHWs and the range of essential services intended to rebuild the trust of the community into the public health

system; (b) within the communities, the poorest households will benefit from increased access to health services; and (c) within households, pregnant women and children will benefit from the BEPHS and the possibilities of transportation to referral facilities.

F. Environment (including Safeguards)

105. **The project is unlikely to harm the environment.** The project's activities will not include large-scale construction, but minor civil works have been proposed for the rehabilitation and expansion of selected health facilities, primarily at the PHU level. However, since project activities are expected to increase the use of health services, the project is likely to increase the generation of biomedical waste. While these consequences are not expected to have long-term detrimental or cumulative effects, the project is classified as Category B.

106. Within the MoHS, the Directorate of Environmental Health and Sanitation (DEHS), with consultant assistance (where necessary), will determine and prepare appropriate instruments for mitigating environmental and social safeguard impacts identified during project implementation. The DEHS will support and be responsible for ensuring project compliance with the safeguard instruments during implementation. The Environmental and Social Management Framework (ESMF) prepared for the EERP has been updated, along with the Matrix of Mitigation measures, which will be funded by the project to avert potential environmental impacts. The ESMF, which includes a Health Care Waste Management Plan (HCWMP), has been disclosed in-country on April 1, 2016, and has been uploaded on the MoHS' website. A copy has also been sent to the Environmental Protection Agency for its record and for monitoring purposes.

G. Bank Grievance Redress

107. Communities and individuals who believe that they are adversely affected by a Bank-supported project may submit complaints to existing project-level grievance redress mechanisms or the Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed to address project-related concerns. Project-affected communities and individuals may submit their complaint to the Bank's independent Inspection Panel, which determines whether harm occurred, or could occur, as a result of Bank noncompliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the Bank's attention and Bank management has been given an opportunity to respond. For information on how to submit complaints to the Bank's corporate GRS, visit http://www.worldbank.org/GRS. For information on how to submit complaints to the Bank Inspection Panel, visit www.inspectionpanel.org.

Annex 1: Results Framework and Monitoring

SIERRA LEONE: Health Service Delivery and System Support Project (P153064)

Results Framework

Project Development Objectives							
PDO Statement The objectives of the project are (a) to increase the utilization and improve the quality of essential maternal and child health services; and (b) in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.							
These results are at	Project level						
Project Development Objective Indicators							
				Cumulative Target Values			
Indicator Name	**Core**	**Unit of Measure**	**Baseline (2013)**	**Year 1 (2016)**	**Year 2 (2017)**	**Year 3 (2018)**	**Year 4 (2019)**
1. Percentage of pregnant women attended 4 or more times by any health personnel		Percentage	78.9	83	86	89	91
2. Percentage of births attended by skilled health personnel (doctors, midwives, nurses and MCH assistants)	X	Percentage	72.4	76	79	81	83
3. Percentage of pregnant women receiving Tetanus Toxoid (TT) 2 or more times		Percentage	89.3	92	94	95	96
4. Percentage of children (0–11 months) fully vaccinated	X	Percentage	86.5	89	91	92	93
5. Direct project beneficiaries (number), of which (a) female (percentage) and (b) located at more than 5 km from a PHU							
Population Population > 5 km Pregnant women (number) Pregnant women > 5 km	X	Number Number Number Number	6,190,280 1,238,056 309,814 61,971	6,327,301 1,265,460 316,713 63,343	6,467,355 1,293,471 323,723 64,745	6,610,508 1,322,102 330,889 66,178	6,756,831 1,351,366 338,213 67,643
Children 0–11 months Children 0–11 months > 5 km		Number Number	247,611 49,522	253,092 50,618	258,694 51,739	264,420 52,884	270,273 54,055

Intermediate Outcome Indicators							
Component 1							
6. Percentage of hard-to-reach communities with at least one active CHW present		Percentage	37	45	70	90	90
7. Percentage of households safely storing and handling drinking water (inspected population)		Percentage	4.3	10	15	20	30
8. Number of outpatient visits per 10,000 population		Number	5,709	6,000	6,300	6,615	6,950
9. Percentage of CHWs rated as 'good performer' by their community		Percentage	0	0	50%	70%	80%
Component 2							
10. Student intakes: Clinical specialization (including Surgery, Pediatrics, Internal Medicine, Obstetrics and Gynecology, Family Medicine) Midwives	X X	Number Number	2 0	10 60	12 120	14 120	14 120
11. Percentage of routine/HMIS reporting units submitting timely and complete reports according to national guidelines		Percentage	75	80	85	90	95
12. Percentage of maternal deaths reviewed among suspected maternal deaths		Percentage	0	60	70	80	90
13. Percentage of SLA applications approved (or recommended for resubmission) within 6 weeks from the date of submission		Percentage	100	100	100	100	100

Indicator Descriptions				
PDO Indicators	**Description (Definition and so on)**	**Frequency**	**Data Source/ Methodology**	**Responsibility**
Percentage of pregnant women attended 4 or more times by any health personnel	Numerator: Number of women (15–49 years) who were attended four or more times by any health personnel during pregnancy Denominator: Number of pregnancies expected among women (15–49 years)	Annual	HMIS	DPI
Percentage of births attended by skilled health personnel (doctors, midwives, nurses, MCH assistants)	Numerator: Number of women (15–49 years) who were attended during delivery by skilled health personnel (doctors, midwives, nurses, and MCH assistants) Denominator: Number of deliveries expected among women (15–49 years)	Annual	HMIS	DPI
Percentage of pregnant women receiving Tetanus Toxoid (TT) 2 or more times	Numerator: Number of women (15–49 years) receiving two or more TT injections during pregnancy Denominator: Number of pregnancies expected among women (15–49 years)	Annual	HMIS	DPI
Percentage of children (0–11 months) fully vaccinated	Numerator: Number children (12–23 months) receiving all of the basic vaccinations Denominator: Number of children (12–23 months)	Annual	HMIS	DPI
Direct project beneficiaries (number), of which (a) female (percentage) and (b) located at more than 5 km from a PHU	Direct beneficiaries are people or groups who directly derive benefits from an intervention (population, number and percentage of pregnant women and children of 0–11 months)	Annual	Census	Statistics Sierra Leone
Intermediate Outcome Indicators	**Description (Definition and so on)**			
Component 1				
Percentage of hard-to-reach communities with at least one active CHW present	Numerator: Number of hard-to-reach communities where at least one active community health work is present (active as defined as 'who reported at least once in the last three months') Denominator: Number of hard-to-reach communities	Annual	CHW Program data	MoHS (DPHC)
Percentage of households safely storing and handling drinking water (inspected population)	Numerator: Number of households safely storing and handling drinking water Denominator: Number of households inspected storing drinking water in their home	Annual	ESICOME Program data	MoHS (DEHS)
Number of outpatient visits per 10,000 population	Numerator: Number of outpatient visits per year Denominator: Population estimate	Annual	HMIS	MoHS (DPI)
Percentage of CHWs rated as 'good performer' by their community	To determine: Definition of 'good performer'; definition of 'community' To determine: Out of all the CHWs or only the CHWs located in hard-to-reach communities	Annual	CHW Program data	MoHS (DPHC)
Component 2				
Student intakes: Clinical specialization (including surgery, pediatrics, internal medicine,	Numerator: Number of students entering the first year of (a) clinical residency training or (b) midwife training	Annual	SLCPGCHS and Midwife Training	SLCPGCHS and Midwife

obstetrics and gynecology, family medicine) Midwives			Schools Records	Training Schools
Percentage of routine/HMIS reporting units submitting timely and complete reports according to national guidelines	Numerator: Number of health facilities (PHUs, DHs, and so on) submitting complete and timely monthly reports (to the districts) Denominator: Total number of health facilities expected to report in the time period	Annual	HMIS	MoHS (DPI)
Percentage of maternal deaths reviewed, among suspected maternal deaths	Numerator: Number of maternal death reviewed Denominator: Number of deaths of women of reproductive age reported	Annual	MDSR and IDSR Programs	DPI
Percentage of SLA applications approved (or recommended for resubmission) within 6 weeks from the date of submission	Numerator: Number of SLA applications approved (or recommended for resubmission) within 6 weeks of the date of submission Denominator: Number of SLA applications received during the period	Annual	SLA Program data	MoHS (SLA Sec.)

Annex 2: Detailed Project Description

SIERRA LEONE: Health Service Delivery and System Support Project

Overview of the Project and Project Components

1. The government's Post-Ebola Recovery Strategy comprises three phases: (a) getting to and then maintaining zero cases of Ebola; (b) implementing immediate recovery priorities; and (c) transitioning back to the Agenda for Prosperity (2013–2018).[44] The strategy's two key (presidential) priorities for the health sector are (a) to restore health services and build a robust health care system that is resilient and strengthened to ward off emergencies and recurring tropical diseases and (b) to reduce maternal, new born, and child mortality and morbidity.

2. The MoHS Post-Ebola Health Sector Recovery Plan (2015–2020) supports each of these phases: early recovery (July 2015–March 2016), recovery (April 2016–December 2017), and health system strengthening and resilience building (2018–2020). The plan addresses five key priorities: (a) patient and health worker safety; (b) health workforce; (c) essential health services; (d) community ownership; and (e) information and surveillance.

3. To date, the Bank-financed EERP has provided support to Guinea, Liberia, and Sierra Leone. The original project in the amount of US$105 million was approved on September 16, 2014, became effective on September 19, 2014, and had an original closing date of September 30, 2015. Additional financing (US$285 million) was approved by the Bank in November 2014, and the closing date was extended to September 30, 2016. By July 2015, the project had achieved all of the PDO indicator targets. Project restructuring is under way to (a) modify the PDO from response and mitigation to support the three countries' post-Ebola health recovery efforts and (b) extend the project closing date to September 30, 2019.[45]

4. The restructuring of the EERP coincides with the preparation of the HSDSSP, which is designed to contribute to the flagship programs proposed by the Health Sector Recovery Plan. The HSDSSP is a three-year US$15.5 million (IDA US$10 million and ERRTF US$5.5 million) project with the PDO of (a) increasing the utilization and improving the quality of essential MCH services; and (b) in the event of an Eligible Crisis or Emergency, providing immediate and effective response to said Eligible Crisis or Emergency. The PDO responds specifically to the second presidential priority for the health sector, the need to improve MCH outcomes, which remain the worst in the world.

5. As conceived, the EERP and HSDPSSP will (a) share a common programmatic framework; (b) provide complementary financial inputs,[46] and (c) use the same fiduciary arrangements. Other implementation synergies, particularly with the proposed REDISSE, may also be possible.

6. The project components are expected to address these two major concerns. First, in the immediate aftermath of the Ebola epidemic, which devastated the country throughout 2014, Sierra

[44] The Agenda for Prosperity (2013–2018) is Sierra Leone's third-generation PRSP.
[45] As of mid-February 2016, the EERP has approximately US$27 million of undisbursed funds.
[46] The EERP is expected to disburse the bulk of the remaining funds in 2016–2017, while HSDSSP will provide continuing funds over 2017–2019.

Leone's already weak health care delivery system suffered multiple shocks with the loss of scarce health human resources[47] and the reallocation of resources routinely allocated for health services delivery to the Ebola response, limiting the ability of the sector to deal with other normally treatable conditions.[48] Community confidence in the health sector has declined, negatively affecting utilization, with drops of 23 percent in institutional deliveries, 21 percent in children receiving basic immunization (penta3), and 39 percent in children treated for malaria.

7. Second, despite significant levels of health expenditure by the government, donors, and households, health outcomes are worse than in countries with comparable socioeconomic characteristics and health spending. Certain indicators have improved over 2008–2013, but Sierra Leone's MCH outcomes remain extremely high and the worst globally: (a) maternal mortality is estimated at 1,165 per 100,000 live births; (b) infant mortality is estimated at 92 per 1,000 live births; and (c) under-five mortality is estimated at 156 per 1,000 live births.

8. Consequently, Component 1 (Health Service Delivery) aims to restore community confidence in publicly provided health services by (a) strengthening the existing CHW cadre and their ties to the PHUs and the facility management structures and (b) revitalizing the PHA cadre to improve the implementation of the environmental sanitation strategy. Component 1 will also focus on (a) reinforcing the linkages between the PHU and the DHs with human and material support to the facilities at both levels (to include equipment, drugs and medical supplies, and potentially infrastructure support, such as running water, solar lighting, solar refrigerators, and so on) and (b) organizing a national ambulance service to ensure the timely transfer of urgent cases from the periphery to the referral facilities.

9. Component 2 (Health System Support) will focus on health human resources and health sector management and coordination. Programs will be established to initiate the training of two types of health personnel: (a) specialists in the areas of obstetrics and gynecology, pediatrics, surgery, and internal and family medicine and (b) physician assistants, midwives, nurses, paramedics, and other cadre of health care workers. The training will enhance service delivery by (a) improving quality at the primary, secondary, and tertiary levels and (b) increasing efficiency (particularly at the hospital level) by enabling task shifting.

10. In addition, the project will provide technical support for capacity building at the central and district levels. The project will also provide support for the implementation of the SLA, a ministry-led initiative to better plan and monitor the interventions of the local IPs that are supporting service delivery efforts of district facilities. Finally, the project will support (together with the EERP, Global Fund, GAVI, and other funding sources) the services of an IHPAU to ensure the fiduciary aspects of project implementation.

Detailed Description of the Project Components

11. The PDO will be achieved through complementary Bank financing (the EERP, HSDSSP,

[47] Ebola infections among health care workers have resulted in 221 deaths, including 11 specialized physicians. Furthermore, the Bank estimates that the loss of health care workers will have a significant impact on future non-Ebola mortality; that is, maternal mortality could increase by 74 percent in Sierra Leone due to the health care worker impact of Ebola unless key doctors, nurses, and midwives are immediately hired.

[48] This has led to increases in malaria, measles, and other vaccine-preventable diseases.

and potentially REDISSE) and coordinated interventions (with other development partners) to empower communities, strengthen the health facilities, and increase the health administration's capacity to plan, implement, and monitor the contributions to improve health outcomes for mothers and children.

Component 1: Health Service Delivery (IDA US$7.3 million equivalent; ERRTF US$3.8 million)

12. Component 1 will contribute to the restoration of confidence in the public sector provision of health care services to the project beneficiaries. Two subcomponents are planned (a) to strengthen community-level service delivery and (b) to enhance facility-level services and ensure emergency transport, especially for pregnant women, from communities and PHUs to the DHs.

Subcomponent 1: Community-Level Service Delivery

13. **Community outreach (CHW Program) and engagement.** Drawing on the contributions of CHWs to the national response to the Ebola outbreak,[49] the MoHS has recognized their importance as key players for (a) improving community access to basic health care and information for mothers and children and (b) acting as change agents for promoting healthy behavior and health-seeking behavior and increased community engagement and ownership of health service delivery. CHWs have been included in the BPEHS 2015[50] and the Health Sector Strategic Plan 2015–2020.

14. The MoHS is currently revising the CHW policy adopted in 2012.[51] The revised policy focuses on (a) strengthening a cadre of health personnel, recognized by the community, selected on the basis of specific criteria, and trained to deliver a minimum package of health services and (b) providing these services to hard-to-reach areas, defined as communities that are more than 5 km or more than one hour's walk from a health facility.[52] Among others, the revised policy aims to (a) establish a feasible ratio of CHWs to the population (currently estimated by the MoHS at 1 CHW per 100–500 persons); (b) provide more intensive initial training; (c) ensure adequate supplies and supportive supervision; and (d) incentivize the work with a motivation package including financial and nonfinancial incentives.[53] Nonfinancial incentives include badges/identification cards, T-shirts, backpacks, torchlights, pens, pencils, erasers, notebooks, soap, and rain gear, all aimed at facilitating delivery of services in the community. In addition to the Bank, UNICEF, the Global Fund, DFID, and USAID are contributing to the program, as well

[49] CHWs played key roles in four areas: (a) Community event-based surveillance and EVD alerts (with more than 95,000 between December 2014 and May 2015); (b) contact tracing; (c) participation in safe burial teams; and (d) behavior change (handwashing, early care seeking, and so on).
[50] The BPEHS 2015 recognizes CHWs as part of the PHC system in Sierra Leone and lists the types of services they are expected to provide.
[51] Before 2012, CHW programs in the country had been fragmented and vertical and overseen and implemented by different ministry directorates and NGOs.
[52] The policy also affords flexibility to the DHMTs to identify areas not considered hard to reach according to this definition but which may require additional health services due to poor indicators.
[53] International evidence as well as studies from Sierra Leone suggest that incentives and regular supervision are essential for ensuring high-quality work and retention of CHWs. See also Sarah Adomakoh, Addressing CHW's Motivations, Performance and Retention in a Fragile or Resource Poor Setting (Save the Children, 2014).

as numerous NGOs and technical partners.

15. The MoHS estimates that about 15,000 CHWs will be required to cover the country; an ongoing geo-mapping of the CHWs, as well as a consideration of hard-to-reach and otherwise in-need communities at the district level, will provide additional information. Of the total number needed, the MoHS estimates that about 5,000 will be needed to cover the hard-to-reach areas. The EERP and HSDSSP will finance (a) financial and nonfinancial incentives for about 5,000 CHWs; (b) routine supervision costs for the peer supervisors and the chiefdom supervisors; and (c) overall coordination and evaluation of the program.

16. Community engagement will be a core principle of the CHW initiative: (a) communities will be involved in the selection and annual assessment of the CHWs' performance and (b) existing community structures, such as the VDC and the FMC of the local PHU, will enhance accountability for the health services delivered to the population. To strengthen community engagement, the project will finance (a) development of appropriate tools for community assessment of the availability and quality of services at the community level; (b) periodic discussion of CHW performance with community members, relevant local authorities, and health staff; and (c) feedback of the results of these discussions to district and national officials.

17. **Environmental health and sanitation.** The DHS (2013) suggests that almost half of the population has no access to safe drinking water, and only 13 percent has access to improved non-shared sanitation facilities. The situation is worse in rural than in urban communities, with rural communities having 34 percent of safe water access compared to coverage of 84 percent for urban communities. In the aftermath of Ebola, there is increased interest in adequate sanitation, solid waste management, and positive hygiene behavior.

18. Consistent with the current legislation, LCs (and other local-level structures) have a clear mandate for the implementation of premises inspection, with the MoHS providing strategic direction and support to enable councils to perform their roles effectively. With the adoption of the ESICOME, the MoHS seeks to (a) target the owners and occupants of domiciles and commercial premises and (b) ensure that they develop and maintain good sanitation on their properties and environs.

19. The ESICOME strategy will rely on a combination of sustained public health education and enforcement of sanitary regulations where behavioral change and communication strategies are not successful. To strengthen the regulatory framework, the HSDSSP will finance technical assistance and support for (a) completion of the National Environmental Health and Sanitation Policy and Strategy; (b) revision and update of the Public Health Ordinance (1960);[54] (c) dissemination of the policy, strategy, and regulatory guidelines; and (d) implementation of the standard operating procedures. The EERP will finance capacity building of environmental health and sanitation personnel and sensitization of the general public.

20. Premises inspection has been routinely (but haphazardly) carried out by PHAs under the direction of PHIs). The EERP and HSDSSP will finance the professionalization of this cadre of

[54] The current Public Health Ordinance, dating from 1960, was clearly demonstrated to be obsolete during the Ebola epidemic.

PHAs by providing (a) training of 400 PHAs (in Freetown, Bo, and Makeni);[55] (b) equipment (especially identity cards, uniforms, start-up kits, personal protective equipment, and so on); and (c) routine operational expenses (materials, transport, supervision, and so on) to implement the initiative nationally.

Subcomponent 2: Facility-Level Service Strengthening

21. Based on the need to establish high-quality health services at the PHU and DH levels and to ensure emergency transport from the PHU to the DH when necessary, the project will finance measures to strengthen PHUs' and DHs' ability to deliver quality high-impact services (especially for MCH conditions) and to organize emergency transport through the establishment of a national ambulance service.

22. **MDCTs/facility-level support**. Included in the EERP additional financing, FMTs[56] were expected to staff emergency treatment units.[57] With the end of the Ebola crisis, the MoHS has shifted its focus from (a) FMTs to MDCTs and (b) epidemic response to comprehensive health service delivery, with a particular emphasis on maternal, newborn, and child health services. Because Sierra Leone expects the return of a significant number of medical doctors over the next 12–18, months, the MDCTs will provide crucially needed services over that period.

23. Under the component, 43 medical doctors, 4 radiographers, 4 laboratory technicians, 23 midwives, and 23 nurses will be recruited and deployed among 22 government hospitals located throughout the country. The MDCTs will provide (a) direct service delivery in the hospitals in which they are deployed, thus increasing the number of available medical specialists and (b) capacity building and skills transfer through in-service training and on-the-job coaching and mentoring of national staff counterparts who are already serving in the same public hospitals. The MDCTs will be deployed in government hospitals at the regional and district levels. In the regional hospitals (Bo, Kenema, Makeni/Bombali, and Connaught/western area), the MDCTs will be composed of medical doctors, radiographers, and laboratory technicians. In the DHs, the teams will include medical officers and surgeons capable of providing essential medical services, especially emergency obstetric care), midwives, and PHC nurses. The EERP will finance the recruitment, deployment, and coordination of the MDCTs. The EERP and HSDSSP will share the costs of procuring urgently required equipment and supplies as well as essential drugs as needed.

24. **EMS**. In Sierra Leone as elsewhere in Africa, distance and lack of transport are major obstacles and causes of delays for surgical and obstetric referral. A study in the Bo District showed that the establishment of an ambulance system (a) increased the number of women with major obstetric complications coming to the hospital (from 0.9 to 2.6 per month) and (b) reduced the case

[55] There are currently 225 trained PHAs, and the overall national target is 1,000 PHAs.
[56] The WHO defines an FMT as a group of health professionals (doctors, nurses, paramedics, and so on) that treat patients affected by emergency or disaster. FMTs have a long history, but WHO has only recently established a classification system and minimum standards for them. The WHO further states that FMTs must (a) present credentials that meet a minimum acceptable standard; (b) provide a quality of care appropriate for the context; and (c) strive for self-sufficiency, so it can respond with success rather impose a burden on the national system.
[57] The goal of the additional financing was to support the deployment of 20 FMTs, consisting of 700–1,000 additional health workers by December 2014 to help meet the 70-70-60 targets set by the UN Mission for Ebola Emergency Response and WHO.

fatality rate from 20 percent to 10 percent.[58]

25. As a part of the Ebola response, more than a hundred ambulances were procured by or donated to the government to facilitate the transfer of suspected EVD cases to Ebola treatment centers. Capitalizing on these investments and with initial support from the ongoing EERP, this component will support the establishment of EMS to improve service delivery, especially for emergency obstetric care.

26. The full details of the EMS system (for example, management structures, staffing and training, financing and sustainability, and so on) will be developed by consultants, based on principles established by the MoHS.[59] The EERP will finance (a) a civil works program comprising the construction of a depot (for ambulance storage and decontamination and maintenance services) and protective fencing; (b) national publicity and a call center; and (c) salaries, management, and operational costs for the first two years. The HSDSSP will finance initial training for up to 165 drivers and 500 paramedics.[60]

Component 2: Health System Support (IDA US$2.7 million equivalent; ERRTF US$1.7 million)

27. Component 2 will contribute to the development of health human resources and sector management and coordination. Three subcomponents are planned to (a) develop critical cadres of health human resources to strengthen service delivery at the PHU and DH levels; (b) improve the oversight and management performance of the MoHS at the central and district levels; and (c) ensure effective project management and M&E.

Subcomponent 1: Health Human Resource Development

28. The component will develop two complementary cadres of staff for deployment to PHUs and DHs: (a) specialists in the areas of obstetrics/gynecology, pediatrics, surgery, and family and internal medicine and (b) physician assistants, nurses, and midwives with skills to enhance the quality and efficiency of service delivery.

29. **Clinical residency training**. Sierra Leone suffers from an exceptionally low number of clinicians actually practicing medicine and surgery.[61] Except for midwifery, foreign medical

[58] O. Samai, et al. 1997. "Facilitating Emergency Obstetric Care through Transportation and Communication in Bo, Sierra Leone." *International Journal of Gynecology and Obstetrics*.

[59] The MoHS has determined that ambulance services will (a) be regulated by a National Ambulance Commission; (b) be stationed at regional hospitals and national fire force stations; (c) be expected to provide full geographic coverage across the territory of Sierra Leone (rather than implementing in one region first and then expanding to other regions over time); and (d) increase the density of EMS teams as time, resources, and demand permit/require. In addition, the MoHS intends to contract the management of the ambulance service to the private sector, and an IFC team has begun discussions on the elements of the proposed PPP aspect of this initiative.

[60] Paramedic training will be equivalent to that of basic life support, with an expected 4–6 weeks' training program using a standard curriculum. Ambulance teams will consist of two paramedics, including a driver, and teams will be available 24/7.

[61] For a population of 6 million, Sierra Leone has less than 150 physicians on regular clinical duty, including 2 pediatricians, 1 radiologist, 1 (retired) pathologist, less than 5 infectious disease specialists (of which several died from Ebola and none are in public hospitals), less than 20 surgeons, 1 anesthesiologist, 0 mental/psychiatry health specialists, 2 qualified pharmacologists outside the public sector, and so on.

schools currently provide postgraduate clinical residency training to the government's health workforce, which contributes to the loss of Sierra Leonean medical personnel as graduates often choose to remain abroad after receiving their training despite the government's expenditure.

30. To reverse this trend, local specialist training will be established through the SLCPGCHS and the THCA. The parliament enacted the SLCPGCHS Act on February 4, 2016, and the THCA Act on March 3, 2016.[62] By authorizing the local training of specialists, the legislation will increase the number of specialized staff able to provide high-quality tertiary care and accelerate the pace of skills transfer to junior medical officers.

31. This subcomponent will support local specialist training by financing (a) the initial expenses of the implementing institutions identified by the legislation and (b) the program costs for training specialists in surgery, pediatrics, obstetrics and gynecology, internal medicine, and family medicine. The EERP will fund (a) initial setup of the management board, the council, and the statutory management positions; (b) improvement of the library and clinical skills laboratory; and (c) the costs associated with accrediting the specialist programs. The HSDSSP will support local specialist training by financing (a) recruitment of consultant trainers; (b) stipends for clinical resident specialists in surgery, pediatrics, obstetrics and gynecology, internal medicine, and family medicine; and (c) program coordination costs.

32. **Auxiliary health worker training.** Established shortly before the outbreak of the Ebola epidemic, the School of Clinical Sciences in Makeni was expected to train physician assistants as a strategy for upgrading skills in the DHs and PHUs. During the epidemic, the school was used as an Ebola treatment unit, but the MoHS proposes to organize the first intake of students in 2016.

33. Training is envisioned for two cadres of mid-level health staff: (a) CHOs, who will be trained as physician assistants to permit task shifting from medical officers in the DHs, and (b) midwives, who will provide a critical link with the PHC system, conducting capacity building, coaching, and mentoring for staff in PHUs with an emphasis on improving quality of care as well as early detection and referral of patients requiring services provided by the MDCTs at the district level.

34. For the CHO training, the EERP will finance (a) renovation of the School of Clinical Sciences; (b) construction of library and boarding facilities; and (c) procurement of transportation. The HSDSSP will finance (a) acquisition of dormitory, classroom, and laboratory material and (b) development of the curricula, pedagogical materials, and books. The EERP will also finance the costs of providing instruction and paying teaching and administrative staff.

35. For the midwives training, the HSDSSP will finance graduate midwifery training courses for nurses in Freetown (18 months) and Makeni (24 months). Finally, the EERP and HSDSSP will finance the establishment and implementation of a CPD program for medical doctors, nurses, and midwives. The program is currently being piloted at one of the major hospitals in Freetown with support from the WHO, and the HSDSSP will finance its rollout and supervision nationwide.

Subcomponent 2: Sector Coordination and Management

[62] The project will support these costs until line items could be inserted into the government budget for 2017.

36. Project interventions will support the central- and district-level activities.

37. **Support to MoHS directorates.** The EERP and HSDSSP will provide complementary support to the MoHS: (a) the EERP will finance assistance to the ministry through the CMO and the CNO; (b) the HSDSSP will finance implementation of the DRCH; and (c) together, the projects will support the DPI.

38. Technical assistance financed through the offices of the CMO and CNO will support the top management staff and the Directorates of PHC, Training, Human Resources, and Hospitals and Laboratories. Funds to the DRCH will support the implementation of the MDSR initiative. The HSDSSP will finance (a) quarterly reviews of the results of the district investigations of suspicious maternal deaths and (b) a maternal death response fund. The DPI will benefit from capacity established under the RCHP2 and continue to receive support for (a) planning and supervision (annual district planning support, quarterly supportive supervision, annual district reviews); (b) M&E (HMIS development, publication of the quarterly HMIS bulletin); (c) organization of special sector studies (national health accounts, health sector financing strategy, and so on); and (d) operational costs.

39. **Support to the DHMT.** As the district-level structure of the MoHS, DHMTs are the primary implementers of the BPEHS and the National Health Sector Strategic Plan. As such, they are responsible for planning, implementing, and monitoring health service provision; their tasks include supplying equipment and drugs to health facilities within the district; staff training and supervision; data collection from PHUs and reporting to national level; community engagement; and ensuring that quality and equitable health services reach the population within the district. The DHMTs' leadership and management roles are essential to health service delivery within the district and to the recovery of the health system post-Ebola.

40. However, the DHMTs often struggle to fulfill their defined functions, particularly with respect to using information to inform decision making, including engaging with communities and facilities to ensure understanding and improve service delivery. The DHMT strengthening initiative will include regular monitoring of the district's health situation (including the nonprofit/faith-based and private facilities) and weekly district meetings to review key health outputs, assess indicators of service utilization and quality, and inform decision making on solutions to enhance health facility performance. The HSDSSP will support the implementation of the MDSR by financing (a) investigations of the causes of suspected maternal death both in the communities and in the health facilities and (b) quarterly reviews of the results of the investigations.

41. Costs for the subcomponent will be shared. The EERP will contribute to the annual operational costs of the DHMT, while the HSDSSP will finance the MDSR at the district level.

42. **SLA.** Launched by the president of Sierra Leone in July 2015, SLAs are intended to improve coordination and accountability of donor-supported efforts at the district level. Negotiated and signed by the IPs and health authorities at the central, district, and local levels, SLAs are intended to ensure the consistency of planned interventions with the MoHS' priorities, improve coordination between the MoHS and its IPs, and hold IPs accountable for results of their activities.

43. An Operations Manual has been prepared, which requires that IPs submit an individual project plan and an annual performance plan for approval by the MoHS. The SLAs are then subject to regular monitoring through (a) quarterly reports submitted by the IP to the MoHS and (b) semiannual joint monitoring visits involving the MoHS, the IP, districts, and the donor.

44. Because the initiative is very recent, there are a number of areas for improvement: (a) the SLA approval process; (b) the modalities for supervision and monitoring; and (c) the collection, analysis, and use of the information collected. The EERP will provide program and salary support for the first two years of the project; the HSDSSP will thereafter finance (a) routine supervision costs; (b) semiannual consultations with IPs and development partners; and (c) publication of quarterly updates.

Subcomponent 3: Project Management, Monitoring and Evaluation

45. To enhance the organization and management of the MoHS, the Bank (through the RCHP2 and EERP) and other development partners (Global Fund and GAVI) have supported the establishment of the IHPAU. The IHPAU is intended to provide oversight of all externally financed projects with a view to improving their planning, implementation, and monitoring. From 2016, financing of the IHPAU will be shared proportionally by the participating partners, currently the Bank (through the RCHP2 and EERP and prospectively through the HSDSSP), Global Fund for AIDS, TB, and Malaria, GAVI, AfDB, and potentially by other partners.

Component 3: Contingency Emergency Response (US$0)

46. Sierra Leone has been declared free of Ebola but is currently in a phase of enhanced surveillance to quickly detect any resurgent cases and prevent further spread. Given the moderate to high risk, during the life of this project, that another outbreak of the EVD or other major epidemic may occur and have adverse social and economic impact, this component aims to improve the government's response capacity in the event of an emergency, following the procedures governed by paragraph 13 of OP 10.00 (the CER component under Investment Project Financing). In anticipation of such an event, this emergency component provides for a request from the country to the Bank to support mitigation, response, and recovery in the district(s) affected by such an epidemic.

47. The request will be appraised and reviewed and if found acceptable to the Bank, disbursement will be made for this component. The component will be used to draw resources from uncommitted project funds, as well as 5 percent of the aggregate undisbursed balances of Sierra Leone's portfolio of investment projects, and/or allow the government to request the Bank to re-categorize and reallocate financing from other components to partially cover emergency response and recovery costs. In this case, the PDO will be revised and the scope of the project will be expanded to cover expenditure incurred under this component. It should be noted that this component will not be used to finance salaries nor any expenditures that could trigger any of the Bank's safeguard policies.

48. An '**IRM Operational Manual'** will be prepared by the country with details including FM, procurement, safeguards, and any other necessary implementation arrangement. The manual should be subjected to no-objection by the Bank, in line with the flexibility provided under

paragraph 13 of OP 10.00. Should funding be reallocated within the project through the IRM, the PDO and/or the project's Results Framework, as required, will be adjusted to capture use of these funds through a level-one restructuring. Safeguards will be addressed when/if a crisis happens. The component will be implemented by the MoHS. Disbursements will be made against a positive list of eligible expenditures critical for the sector recovery. The list will consist of goods, maintenance and repairs operating costs, and consultant services needed to deal with the emergency.

49. **Procedures for triggering the CER.** To activate this component in the event of an emergency, the MoHS shall:

(a) prepare and furnish to the Bank for its review and approval an Operations Manual that shall set forth detailed implementation arrangements for the CER, including;

(i) designation of, TOR for, and resources to be allocated to the entity to be responsible for coordinating and implementing the CER (coordinating authority);

(ii) specific activities that may be included in the CER component and any procedures for including them;

(iii) FM arrangements for the CER;

(iv) procurement methods and procedures for expenditures to be financed under the CER;

(v) documentation required for withdrawals of expenditures;

(vi) environmental and social safeguard management frameworks for the CER, consistent with the Association's policies on the matter; and

(vii) any other arrangements necessary to ensure proper coordination and implementation of the CER;

(b) give the Bank a reasonable opportunity to review the proposed Operations Manual;

(c) promptly adopt an IRM Operations Manual;

(d) ensure that the CER is carried out in accordance with this manual; and

(e) not amend, suspend, abrogate, repeal, or waive any provision of the manual without prior approval by the Bank.

50. Throughout the implementation of the CER, the MoHS will maintain the coordinating authority, with adequate staff and resources satisfactory to the Bank, and the MoHS will not undertake activities under the CER unless and until (a) the government has determined that an Eligible Crisis or Emergency has occurred and has furnished to the Bank a request to include relevant activities in the CER to respond to the identified crisis or emergency, and the Bank has

agreed and accepted the request and notified the government thereof; (b) the MoHS has prepared and disclosed all safeguards instruments required for the relevant activities, in accordance with the IRM Operations Manual, the Bank has approved all such instruments, and the government has implemented any actions that are required to be taken under these instruments. Procurement for the CER will be done in accordance with the procurement methods and procedures set forth in the IRM Operations Manual. Before disbursements, (a) a request should be made for using the CER component and this should be accepted by the Bank; (b) safeguard instruments should be prepared and disclosed and necessary safeguard actions, if any, should be implemented; (c) adequate staff and resources should be in place to implement the CER activities; and (d) the IRM Operations Manual should be adopted.

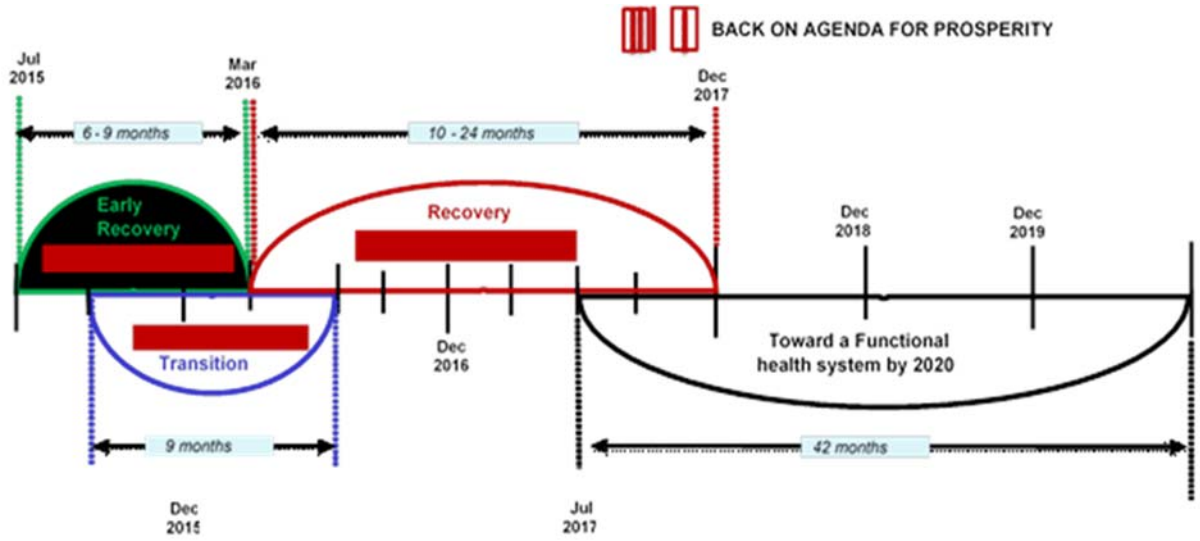
Annex 3: Implementation Arrangements

SIERRA LEONE: Health Service Delivery and System Support Project

Project Institutional and Implementation Arrangements

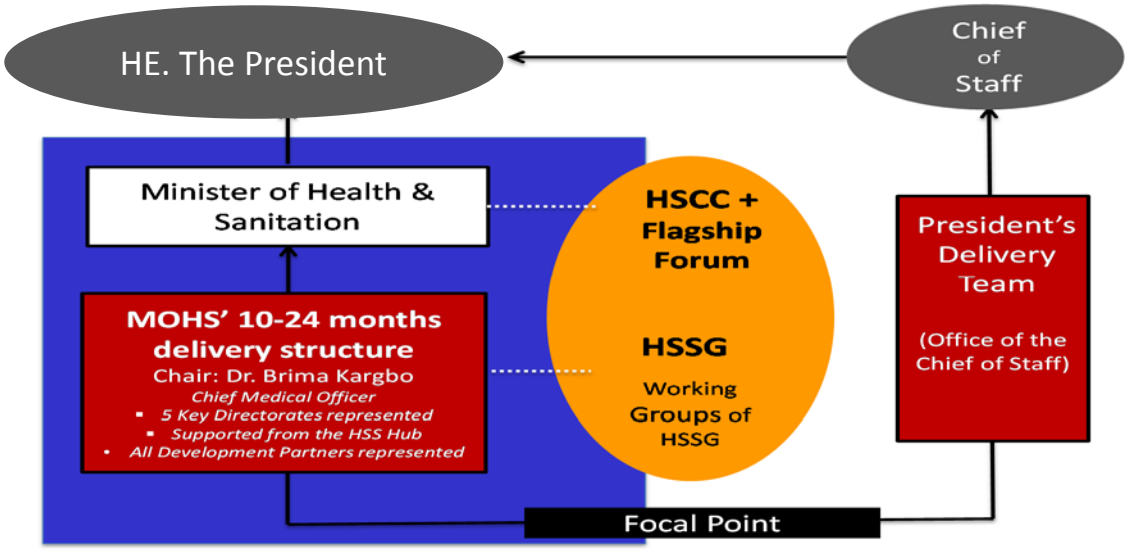
1. With the declaration of an Ebola-free Sierra Leone, the efforts for the recovery and resilience of the health system has begun with the transition from the early recovery to the recovery phase of the post-Ebola efforts. As shown in table 3.1, the early recovery phase has been completed, and the recovery phase (for the next 10–24 months) has commenced. The HSDSSP will support the recovery phase and contribute to the return to a functional health system able to deliver quality services and mitigate and respond to other future epidemics.

Figure 3.1. Transition from the Early Recovery Phase to the Recovery Phase



2. For the recovery phase, the implementation and oversight arrangements have been outlined as follows between the MoHS and the president's delivery team.

Figure 3.2. Implementation and Oversight Arrangements for the Recovery Phase



3. At the government level, the post-Ebola recovery planning in all sectors is coordinated centrally by the Presidential Delivery Unit at the State House, under the guidance of the Chief of Staff who reports to the president on the progress. The sectorial ministries constitute a dedicated unit reporting directly to the Office of the Chief of Staff on the progress of their respective plans as it contributes to the government's post-Ebola goals.

4. The Minister of Health oversees the recovery phase of the ministry's Post-Ebola Health Sector Recovery Plan (2015–2020). Responsibility for planning and implementing the recovery rests with the CMO, in collaboration with the HSCC and the flagship forum. The HSCC is chaired by the Minister of Health and includes the heads of agencies of development partners supporting the health sector. The flagship forum comprises the minister and deputy ministers, the CMO and the two deputy CMOs, the CNO, and the directors of the directorates responsible for the flagship programs supported by the project. The forum meets every two weeks to take stock of progress on reaching the milestones for each of the flagship programs under the recovery plan.

5. The HSDSSP will be implemented by the MoHS under the leadership of the Project Steering Committee. The Steering Committee will comprise (a) the CMO, who will serve as Project Director and provide overall technical guidance and oversight, and (b) the directorates involved in project implementation. The CMO will work closely with the MoFED and local government authorities at the central and district levels to ensure cohesion between the planned flagship initiatives and their district implementation. Each of the subcomponents has been designed with and will be implemented by the relevant MoHS directorate and the DHMTs, which will have technical responsibility for the results. An implementation manual describing the project's contents and procedures will be adopted by the MoHS and approved by the Bank. Arrangements for each of the project subcomponents are discussed in this section.

6. **Community outreach (CHW Program) and engagement.** Since the launch of the national CHW Program in 2012, the MoHS has sought to replace the previously fragmented and

vertical approaches with a more coherent approach. A CHW technical working group has provided technical support; a revised policy was circulated in March 2016 and is expected to be launched by mid-2016.

7. Under the Directorate of Primary Health Care Directorate (DPHC), the MoHS has established (since mid-2015) the national CHW Hub. Staffed by a national coordinator, four regional coordinators, and technical officers for M&E and finance, the CHW Hub will support the focal person identified in each DHMT for the management and supervision of the CHW Program. In the selected districts, the DHMTs will be responsible for the direct implementation of the CHW Program. With support from the CHW Hub, the respective DHMTs are responsible for ensuring disbursement of funds to CHWs and peer supervisors and training of peer supervisors in supervision skills, as well as CHWs. The DHMTs will oversee, coordinate, and complement the efforts of the IPs working with CHWs.

8. Selection of CHWs will focus on hard-to-reach areas, defined as communities more than 5 km or more than one hour's walk from a health facility, though the DHMT may consider other criteria (for example, terrain, health indicators, and so on). In some hard-to-reach areas, CHWs are already working, with some having been involved for several years; in such a circumstance, new CHWs will not be selected, and current CHWs will continue to work with more robust supervision and an annual evaluation. Where new CHWs are needed, selection will be (a) a joint/participatory effort between the community and the in charge of the PHU to which the CHW is attached, and (b) based on the criteria and processes outlined in the revised National CHW Policy.

9. Two conditions will be met before implementation of the program. First, before disbursement, guarantees (from the Human Resource Office, the Public Service Commission, and the MoFED) will be required to ensure the future sustainability of these staff after the end of the project. Second, a simple performance agreement will be signed by the CHW and the community, which (a) defines the roles, responsibilities, and obligations of the CHWs, and (b) indicates the criteria, manner, and timing for evaluating the CHW's performance and potential removal from the program as needed. This agreement will provide the basis for payment of the incentives. Financial incentives for CHWs will be awarded on the basis of monthly reports submitted by the CHW, signed by the peer supervisor, and approved by the PHU in charge. Financial incentives for the peer supervisor will be awarded on the basis of monthly reports submitted by the peer supervisor, attested by the CHW, and approved by the PHU in charge.

10. Training will be (a) competency and skills based with an emphasis on practice, and (b) carried out using a cascade model, with skilled facilitators conducting master training of trainers for the MoHS and IP staff who are then responsible for cascading the training to districts. CHWs are trained by districts at the chiefdom level. CHWs must complete a pre- and posttest to assess their competencies. The National CHW Program expects to retrain all 15,000 CHWs in the revised preservice training package within year 1 of the program (approximately July 2016–July 2017). After that, refresher training will be conducted on a biannual basis, at six days per refresher training.

11. Resupply of the CHWs will vary according to the nature of the goods: (a) essential medicines will be provided through the regular channels, with PHUs reserving 30 percent of drug supplies for use by the CHWs, and (b) forms and printed materials will be distributed at the

monthly PHU meetings or during periodic supervision by the peer supervisors. Other materials (for example, hand sanitizers, bicycles, and so on) will be distributed by the DHMTs.

12. Supervision is ultimately the responsibility of the PHU in charge and involves spot checks, compilation, and analysis of CHW reports, monthly review sessions, and annual participation in the evaluation of CHW performance. Given the volume of work, the PHU in charge is assisted by the peer supervisor, who is a trained and experienced CHW with additional supervisory and mentoring skills. The peer supervisor acts as a link between the CHWs, the community, and the formal health facility. Additional supervision is provided by the chiefdom supervisors as well as CHW Program staff from district, regional, and national levels.

13. **Environmental Health and Sanitation.** Responsibilities for water supply and sanitation are defined in the Public Health Ordinance (1960) and the Public Health Act (1996, amended 2004). However, the Local Government Act (2004) devolves the water supply and sanitation responsibilities to the Ministry of Local Government and Rural Development.[63] Consistent with the legislation, LCs (and other local-level structures) have a clear mandate for the implementation of premises inspection, with the MoHS providing strategic direction and support to enable councils to perform their roles effectively.

14. Within the MoHS, the DEHS is responsible for (a) policy formulation, regulation and standards setting; (b) resource mobilization; (c) information, education, and advocacy; and (d) monitoring and oversight of the efforts of all health care providers and development partners at all levels relating to environment health and sanitation activities. The MoHS has recently adopted the ESICOME strategy, which (a) encourages owners and occupants of all categories of premises to maintain good sanitation on their properties and environs, and (b) relies on both public health education and rigorous enforcement of regulations.

15. At the district level, the Local Government Act 2004 and other legislations provide the LCs and local-level structures with a clear mandate for the inspection of domiciliary and commercial premises. At the district level, inspection teams will comprise one PHI and one or more PHAs, trained by the project. Under the supervision of the district health superintendent and the LC officer in charge of environmental sanitation, the inspection team will be responsible for carrying out the regular ESICOME activities, complying with established work plans and comprehensive check lists.

16. The daily operations of inspection teams shall be recorded day by day and records will be inspected by the DHMT's district environmental health officer (and zonal environmental health supervisors) on a weekly basis except in emergencies or as the need may arise. Monthly reports completed by the environmental health officer will be submitted to the council for compilation of monthly reports using the prescribed forms including narratives of field notes. The district health superintendent will forward the report to the DEHS, where the DEHS will collate the district summary reports into a national monthly summary and submit to the CMO. The CMO will then submit the monthly report to the Minister of Health and Sanitation with copies to the Minister of Local Government and Rural Development.

[63] The Environmental Protection Act (2008) empowers a separate Environmental Protection Agency with the overall mandate of setting and monitoring environmental standards.

17. **MDCTs/Facility Level Support.** The MoHS will be responsible for the implementation of the component. Medical doctors and laboratory staff will be recruited externally; nurses and midwives will be recruited internally from among retired or returned Sierra Leone staff. For the external recruitment, the Directorate of Hospitals and Laboratories (DHL), with support from the Office of the CMO, will (a) advertise through different platforms (for example, African Union, West African College, newspapers, and so on); (b) receive applications; and (c) set up MoHS interview panels, which will select the staff. For the internal recruitment, the CNO will be supported by the office of the CMO and will use similar selection procedures.

18. Management of the MDCTs will be through the DHL and the CNO on technical matters and through the MDCT coordinator on administrative matters. Stipends for MDCTs will be paid by the IHPAU; the WHO and UNFPA will offer technical support in relation to the training curricula to be used by MDCTs in capacity building component.

19. The DHL will coordinate the procurement of equipment and supplies with the support of the biomedical engineer (funded by the IDB) located in the IHPAU. Equipment will be procured internationally, and a maintenance contract for large medical equipment will be negotiated. Consumables will be sourced domestically.

20. **Emergency Medical Services.** As currently envisaged, the EMS system would be governed by a commission[64] responsible for overall direction and policy, standards (including clinical and operational), and licensing of emergency services operators. Operators would include a mix of public, private, and non-governmental emergency services providers. The system would be managed by a small executive unit within the MoHS, which would focus on medical and operational oversight and contract management. Day-to-day management of the ambulance service will be contracted out to the private sector.[65] The full details of the EMS system will be developed by a consulting team, currently being recruited with EERP financing.

21. **Clinical Residency Training.** The project will support the formal creation of the SLCPGCHS and the THCA. Under the legislation adopted by the parliament, the institutional arrangements will be established, and the Board of the SLCPGCHS will recruit a chief medical director, a deputy, and a director of administration. The Board will also recruit the consultant trainers who will provide the initial specialist training.

22. Training is already ongoing for family medicine specialists and will commence for the other specializations in 2016 (surgery, pediatrics, internal medicine, and obstetrics and gynecology). Rotations during the first year will be organized in countries in the sub region; thereafter, rotations will be carried out in Freetown and in the regional hospitals (in Makeni, Kenema, and Bo), which will serve as associated teaching hospitals with specific specializations. The postgraduate medical training coordinator will provide technical assistance during the first two years of operations.

23. **Auxiliary Health Worker Training.** Training of CHOs to serve as physician assistants will take place at the School of Clinical Sciences in Makeni. The Directorate of Training will be

[64] Because establishment of the commission will require an Act of Parliament, legislation will only be available during project implementation.
[65] An IFC team has expressed interest in supporting the proposed PPP aspect of this initiative.

responsible for developing the school's policies and procedures and revising the curriculum. In collaboration with the IHPAU, the Directorate of Training will procure the requisite text books and learning materials. The first intake of students is planned for 2016.

24. Training of midwives will be provided in Freetown (18-month course) and in Makeni (24-month course). The CNO will have overall responsibility for the content of the training courses. Payment of student stipends will be organized by the IHPAU.

25. Under the guidance of the CNO, refresher training on the BPEHS will be organized for nurses and midwives. In addition, the CNO will be responsible for establishing and implementing a CPD program to enhance health facility capabilities for medical doctors, nurses, and midwives.

26. **Support to MoHS directorates.** HSDSSP support will focus on the DPI. The DPI will continue to benefit from consultants already financed by the RCHP2 and will be responsible for (a) planning and supervision (annual district planning support, quarterly supportive supervision, annual district reviews); (b) M&E (HMIS development, publication of the quarterly HMIS bulletin); and (c) organization of special sector studies (national health accounts, health sector financing strategy).

27. The HSDSSP will also support the DRCH in the rollout of the ongoing pilot MDSR initiative. The DRCH will be responsible for (a) technical oversight of the investigations conducted by the DHMT; (b) quarterly review of the results and recommendations for reducing maternal death; and (c) allocation of resources from the Maternal Death Response Fund. The procedures for disbursing resources from this fund will be approved by the Bank and implemented by the IHPAU in collaboration with the DRCH.

28. **Support to DHMTs.** Implementation of the MDSR at the district level will be the responsibility of the DHMT, which will (a) organize the investigations of suspected maternal deaths and the quarterly review meetings, and (b) oversee and report on the use of the Maternal Death Response Fund.

29. **SLAs.** Adopted by the MoHS in July 2015, the SLA constitutes a formal mechanism by which the ministry can delegate parts of its mandate to ensure health care services in Sierra Leone to non-government entities. Subsequently, an implementation manual has been prepared describing the roles and responsibilities of the IP and the MoHS at each stage: pre-implementation (proposal), implementation, and post-implementation. SLA management will be institutionalized within the Partner Liaison Office of the MoHS and report directly to the minister. The SLA Management Unit will be staffed with a program manager, budget analysts, M&E analysts, a database manager, and administrative support staff.

30. The SLA will comprise (a) a summary of the project's goals, objectives, outcomes, outputs, and inputs; (b) a results framework; (c) a detailed budget; and (d) a description of the implementation arrangements. SLA submissions will be reviewed by the SLA secretariat and presented to the program review committee for approval and the top management team of the MoHS for final approval in a process not to exceed six weeks. The SLA will be signed by the MoHS (at the level of the CMO and above) and by the IP. The SLA will be countersigned by the district medical officer and a representative of the LC where the IP will be operating.

31. **Project Management and Monitoring and Evaluation.** Financed proportionally by the participating development partners, the IHPAU comprises five positions: Fund Management Specialist/Team Lead; Finance Specialist; Procurement Specialist; Audit Specialist; and Monitoring, Evaluation, Accountability and Learning (MEAL) Specialist. The IHPAU will oversee the fiduciary elements of all externally financed projects with a view to improving their capacity for procurement, FM, auditing, and monitoring.

Financial Management, Disbursement, and Procurement

32. An FM assessment of the IHPAU of the MoHS was conducted in accordance with OP 10.00 as complemented with the FM guidelines outlined in the Financial Management Practices Manual issued by the Financial Management Sector Board on March 1, 2010.

33. The objective of the assessment was to determine whether (a) the IHPAU has adequate FM arrangements to ensure that project funds will be used for purposes intended in an efficient and economical way; (b) the project's financial reports will be prepared in an accurate, reliable, and timely manner; (c) the entities' assets will be safeguarded; and (d) the arrangements are subject to acceptable audit arrangements by IDA.

34. The overall FM risk for the project at preparation is assessed as High, but with the expected risk mitigation measures when adequately implemented, the residual FM risk is rated as Substantial.

35. **Country issues.** According to the 2014 Public Expenditure and Financial Accountability, which included an analysis of Sierra Leone's Public Financial Management (PFM) strengths and weaknesses, the government has taken considerable actions to improve its public FM since 2010.

36. The adoption of a number of new laws has had a positive impact on the regulatory framework for PFM. The proposed new PFM Law that will replace the Government Budgeting and Accountability Act 2005 and the Public Debt Law passed in 2011 are two important legislations contributing to the enhanced legislative framework. The establishment of the Procurement Directorate and the Public Investment Planning Unit of the MoFED and capacity increases and improvements in the number and quality of staff within the Ministry of Finance, the Accountant General's Department, and the Office of the Auditor General are positive developments in the PFM environment.

37. A weakening of budget credibility and predictability for both expenditures and revenues (underestimated), minor gains in comprehensiveness not affecting fiscal management challenges, weaknesses in expenditure control (including payroll), and low levels of transparency are weaknesses to be addressed as the government considers moving the system to a level that is capable of directing resources to priority areas and supporting high-quality expenditure outcomes.

38. PFM reform in Sierra Leone is directed at all the dimensions of the PFM system. The PFM Reforms Strategy 2014–2017 seeks to develop the basis for the GoSL to accelerate PFM reforms and establish an efficient, effective, and transparent PFM system that minimizes opportunities for corruption.

39. The strategy is being pursued under the following four themes:

- Budget planning comprehensiveness and credibility. Its primary aims are to establish a credible and stable budget process, particularly to establish a transformational and development fund, public investment program, and link investment to recurrent operations and maintenance spending through the MTEF process.

- Financial control and accountability, service delivery, and oversight. The most critical objective of which is to complete the rollout of IFMIS to major spending MDAs and bring all CG public accounts—including subvented accounts and DP project accounts—on to IFMIS.

- Revenue mobilization. Its two objectives will be (a) to establish more effective tax and control regimes for extractive industries through the Extractive Industries Revenue Act and the Oil Exploration Act and (b) to improve the system for recording and reconciling payment and receipts.

- Strengthening local governance FM through LCs for effective decentralization. A critical objective shall be the consolidation of the implementation of the PETRA Accounting Package in all LCs including the real-time processing of transactions by selected councils.

40. The PFM strategy, if successfully implemented, will put in place appropriate structures and processes to promote transparency and accountability and mitigate the fiduciary risk of utilizing public funds both at the country and project levels as well as have positive impact of aggregate fiscal discipline, the strategic allocation of resources and the efficiency of public service delivery. The PFM reform is being supported through a donor financed PFM (PFMICP) project which include DFID, AFDB, and IDA.

41. The bulk of external assistance with regard to programming has been channeled off-budget both in the sense that resource allocations are not reflected in the government's budget documents and those funds are not disbursed through country treasury systems. This lack of information and absence of effective instruments to guide the allocation of external financing seriously undermine the integrity and effectiveness of the budgetary system. There is insufficient transparency in public finances. The budget process is not yet transparent. The ongoing PFMRP project aims to address all the above weaknesses by mobilizing funds from a number of donors to finance a comprehensive public FM overhaul of the respective integrated systems and ensure an inclusion of donor funded projects in government chart of accounts and budgets so that eventually they are able to use existing country systems.

42. **Project risk assessment and mitigation.** This section presents the results of the risk assessment and identifies the key FM risks and the related risk mitigating measures.

Table 3.1. Risk Rating Summary Table

Risk	Risk Rating	Risk Mitigating Measures	Conditions of Negotiations, Board or Effectiveness (Yes or No)	Residual Risk Rating

Inherent Risks					
1	**Country Level** Weaknesses in legislative scrutiny, low human capacity, declining revenues, and energy challenges affecting timely and adequate intergovernmental fiscal transfers.	H	Efforts are being made to help the GoSL substantially resolve and enhance revenue management framework in the medium term. The Public Financial Management Improvement and Consolidation Project seeks to address the human capacity issues including FM capacity and improve process aspects.	No	H
2	**Entity Level** The political arm of the entity and/or management may unduly interfere with, and/or override, project FM controls.	H	An independent project FM unit with officers paid by the project will manage the fiduciary aspects of the project to ensure independence. An independent external audit will be carried out annually under the project. The design of the project will include an enhanced accountability framework to ensure control of soft expenditures from possible abuse. Initially, regular FM reviews will be conducted by the Bank team to provide support.	No	S
3	**Project Level** Weak FM capacity at the ministry could result in slow execution of the project and delayed reporting could impact on progress.	H	The IHPAU will be manned by qualified personnel that will handle the day to day management for the GoSL. The performance of the staff hired in the area will be reviewed once annually to act as a basis for renewal of their individual contracts.	No	S
Control Risks					
4	**Budgeting** Budget and annual work plan preparations may be delayed and may not be comprehensive. Risk of cost overruns and adverse variations in expenditure could arise due to potential slow implementation and padding of the related unit costs of goods and services entailed in the implementation.	M	The project budget has been prepared. The annual work plan would be submitted annually before implementation starts for review by the Bank team which would ensure it is realistic and unit cost estimates are reasonable based on industry and global experiences gathered in some jurisdictions that have undertaken similar operations and also cross check the same with the local market. Also, budget execution reporting through quarterly IFRs will be routinely monitored by IDA with variations in unit costs tracked to ensure major deviations are followed up and investigated. The Budget Office will also monitor budgeted activities to ensure effective use of budgets	No	L

5	**Accounting** Government Accounting System not yet installed at the ministry. Use of manual accounting system not generating reliable, accurate, and timely accounting information for project appropriate decision making acceptable to the Bank.	H	The IHPAU will use a customized accounting system compatible with the government IFMIS.A detailed software guide will be developed to help with its establishment of its functionalities and platform to interface with the government IFMIS systems. The Financial Procedures Manual is being revised to take into account peculiar design of the project and an accounting software acceptable to the Bank installed. The Bank's team will provide support to relevant project staff at the IHPAU for setting up both the software and informational reporting aspects.	No	S
6	**Internal Control** Project funds not being used for intended purposes because of inadequate internal control by management and lack of control measures pertaining to soft expenditures and usage of executive override. This may give rise to noncompliance with internal control procedures.	S	Adequate internal control over the disbursement and accountability of funds for eligible expenditures will be further strengthened by the adoption of an enhanced accountability framework for the project and internal audit oversight on the project at the IHPAU will be instituted. The internal auditors will be required to generate periodic internal audit reports which should be shared with relevant stakeholders including the Bank. The internal control will also be documented in the FM manual for the project. Internal and external auditors would be expected to clearly identify and report any cases of breach of internal control procedures by the project management.	No	M
7	**Fund Flow** Possible delays in processing withdrawal applications leading to problems in honoring payments to third parties. Submission of withdrawal applications delayed.	S	The IHPAU will be responsible for preparing and submitting withdrawal applications, and acceptable service standards for settlement of bills will be established. IDA funds will be disbursed through the U.S. dollar-denominated DA to be opened by the IHPAU. Simplified flow of funds arrangements will be included in the Project Implementation Manual.	No	M
8	**Financial Reporting** Delays in the preparation and submission of un-audited IFRs	M	IFRs shall be submitted to the Bank within 45 days after the end of each calendar quarter. The content of the	No	L

	and/or unreliable IFRs submitted.		IFR will include sources and uses of funds, uses of funds by category, bank accounts reconciliation and a schedule of amounts drawn from the credit.		
9	**Auditing** Delays in the submission of audit reports and the timeliness of management follow up on audit issues.	S	The audit TOR will be agreed and a qualified and acceptable auditor appointed with relevant input of Audit Service Sierra Leone. Continuous satisfactory performance of auditors will be basis for continuous engagement. The audit would be done in accordance with International Standards on Auditing and, International Public Sector Accounting Standards. The audited financial statement is expected to be submitted to the Bank not later than six months after the end of each fiscal year. The TOR for the external auditors has to be cleared by the Bank. The Bank will liaise closely with implementing agencies to ensure that management takes corrective actions on identified weaknesses.	No	M
Overall Risk Rating		H			S

Note: H = High; S = Substantial; M = Moderate; and L = Low.

43. A summary of the key findings of the FM assessment as well as the FM arrangements under the project as conducted is presented as hereunder.

44. **Planning and budgeting.** The respective entities' annual work plans and budgets (AWPBs) will be prepared and approved based on the policy guidelines and strategy planning as laid-out in the PIM to be developed, and consistent with the provisions of the Government Budgeting and Accountability Act 2005.This budget will be activity based and in line with the cost tables of the project. The AWPB is expected to be prepared in a participatory way and approved before the new financial year. The financial part will be monitored during project implementation using unaudited IFRs. The IHPAU will ensure timely preparation, review, consolidation, and approval of the AWPB.

45. **Accounting policies, system and procedures.** The IHPAU will set up and maintain books of accounts specifically for this project. Books of accounts will include a main cash book, and ledgers, fixed asset registers, and contracts register. The IHPAU will use a customized FM system and will ensure that codes for the transactions are adequately reflected in its books.

46. The accounting systems will contain: (a) charts of accounts and coding systems able to capture transactions classified by project components and IDA disbursement categories; (b) use of the cash or modified cash method of accounting; (c) a double entry accounting system; and (d) the production of annual financial statements and quarterly IFRs in a format acceptable to IDA.

47. An accounting policies and procedures manual will be prepared to include the project financial transactions procedures at each of the implementing agencies. The Manual will contain the necessary internal controls including internal checks and segregation of duties.

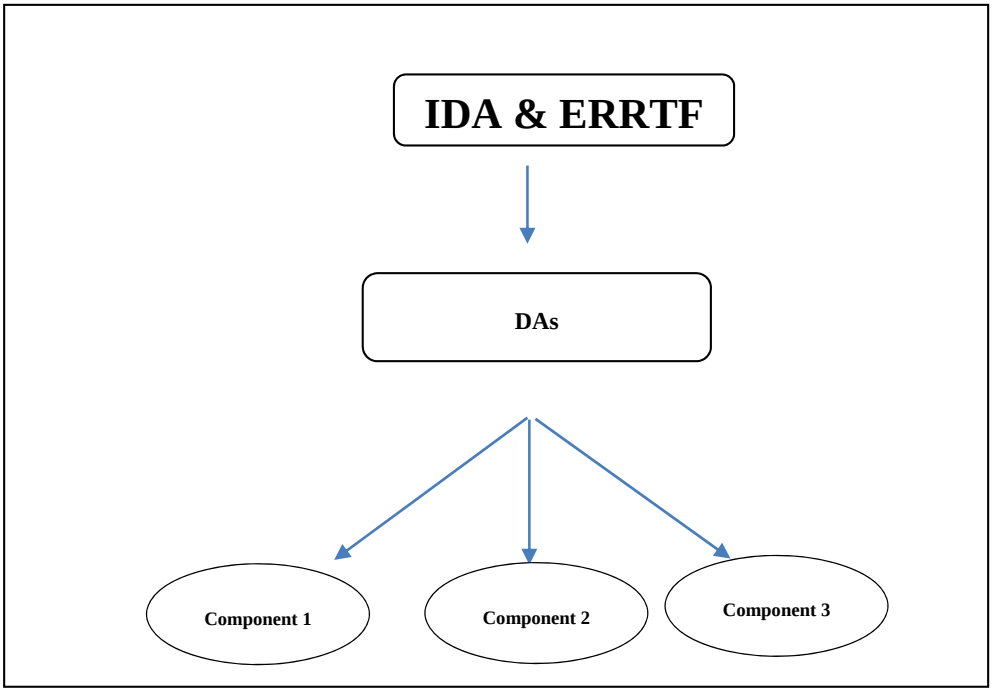
48. **Internal audit and control.** The Internal Audit Unit of the IHPAU will carry out periodic internal audit reviews of activities carried out in the implementation of the project and share copies of their report with the Bank.

49. Segregation of duties and full compliance with the provisions of the PIM, especially as pertaining to internal control aspects, will remain key in implementing the expenditure processing activities at the IHPAU and the executing agencies during the life of the project.

50. **Governance and Anticorruption.** The Bank's Anti-Corruption Guidelines *(*'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants', dated October 15, 2006 and revised in January, 2011) apply to this operation. Sections of these guidelines, especially those relating to conflict of interest, procurement and contract administration monitoring procedures, procedures undertaken for replenishing the DA, and use of the project's asset shall be provided as an annex to the project's Financial Procedures Manual. Additional mitigation measures will include advocating good governance, close monitoring, spot checks by the internal audit units, and enhanced social responsibility by the GoSL and implementing entities.

51. **Flow of Funds.** The flow of funds will be as follows:

Figure 3.3. Flow of Funds



52. **DA.** To facilitate funds flow to the GoSL, a segregated DAs—one for the IDA Credit and the other for the ERRTF Grant—will be opened in U.S. dollars at a commercial bank acceptable

to the Bank and managed by the IHPAU. The DAs for both the IDA and ERRTF funds will cater to the implementation requirements for all the components as specified in the legal agreements.

53. **Disbursement arrangements.** The transaction (statement of expenditure)-based disbursement method will be used as a basis for the withdrawal of credit and grant proceeds. The project provides for the use of 'advances, reimbursements, direct payment, and special commitments' as applicable disbursement methods, and these will be specified in the disbursement letter.

54. Supporting documentation will be retained by the implementing agencies for review by the IDA missions and external auditors.

55. **Retroactive financing.** Retroactive financing not exceeding SDR 1,420,000 (approximate US$2,000,000) from the IDA Credit and US$1,000,000 from the ERRTF will be considered eligible for expenses incurred under all components and not later than twelve months before the signing date of the Financing Agreement. Activities to be financed under the retroactive financing include project preparation, preparation of project implementation manual, training and capacity building for the project, procurement of drugs, and medical supplies through pre-financing by partners and stakeholder engagement.

56. **Financial reporting arrangements.** The IHPAU will be responsible for the preparation and submission of quarterly IFRs for the project, to be submitted within 45 days after the end of the quarter to which they relate. It will also be responsible for the preparation of the annual financial statements for the fiscal period to which they relate and having them audited. The information in these reports will be clearly linked with the chart of accounts for the project.

57. The following quarterly IFRs and annual Financial Report will be produced:

(a) A statement of sources and uses of funds for the reported quarter and cumulative period from project inception, reconciled to opening and closing bank balances.

(b) A statement of uses of funds (expenditures) by project activity/component, comparing actual expenditures against budget, with explanations for significant variances for both the quarter and cumulative period.

58. The annual financial statements should be prepared in accordance with International Public Sector Accounting Standards (which, among others, include the application of the cash basis of recognition of transactions) and International Standard on Auditing within six months after the end of each fiscal year.

59. The Financing Agreement will require the submission of audited financial statements to the Bank within six months after the end of each financial year. These Financial Statements will comprise:

(a) a Statement of Sources and Uses of Funds/Cash Receipts and Payments, which recognizes all cash receipts, cash payments, and cash balances controlled by the project entities and separately identifies payments by third parties on behalf of the project entities;

(b) a Statement of Affairs/Balance Sheet as at the end of the financial year, showing all the assets and liabilities of the project;

(c) the Accounting Policies Adopted and Explanatory Notes. The explanatory notes should be presented in a systematic manner with items on the Statement of Cash Receipts and Payments being cross-referenced to any related information in the notes. Examples of this information include a summary of fixed assets by category of assets and a summary of withdrawal schedule, listing individual withdrawal applications; and

(d) a Management Assertion that IDA funds have been expended in accordance with the intended purposes as specified in the relevant Bank legal agreement.

60. Indicative formats of these statements will be developed in accordance with fiduciary requirements and agreed with the Country Financial Management Specialist.

61. **External audit.** The Audit Service Sierra Leone is by law responsible for the audit of all government finances and projects. However, in view of the prevailing capacity constraints, it is likely that the Audit Service Sierra Leone could outsource such service to a private firm of auditors with qualifications and experience acceptable to the IDA, subject to the IDA/IBRD procurement guidelines for the selection of consultants as revised in January 2011.

62. The IHPAU will be responsible for preparing the project financial statements on which the auditor will issue a single opinion covering project accounts, the usage of statement of expenditures, and the management of DAs. In addition, a management letter outlining any internal control weaknesses will also be issued by the external auditor together with the audit report.

63. The project financial statements will be audited annually in accordance with International Standard on Auditing by independent auditors acceptable to IDA based on TORs acceptable to IDA as above annotated. The auditors should be appointed before the first audits period to allow the auditors to be able to submit the audit report within the due date. The audited financial statements will be submitted to IDA within six months after the end of each fiscal year. The cost of the audit will be financed from the project proceeds.

64. **Fraud and corruption.** Inefficient service delivery due to poor governance practices and weak PFM environment is an inherent issue. Actions to circumvent the internal control system such as colluding practices, bribes, abuse of administrative positions, mis-procurement among other considerations are critical risks that may arise. Other internal control incidences that may expose the project to fraud and corruption include, but are not limited to: (a) late submission of supporting documents; (b) poor filing and records; (c) lack of work plans and or budget discipline; (d) unauthorized commitment to suppliers; and (e) bypassing budget and expenses vetting procedures. The project shall mitigate these potential fraud and corruption related risks through: (a) strengthened project monitoring; (b) specific aspects on corruption auditing, which will be included in the TORs for the external audit; (c) targeted FM procedures and internal control mechanisms across the project activities, which shall be detailed in the project OM; (d) strong FM staffing arrangements; (e) periodic FM supervisions; (f) IFRs reviews and monitoring; and (g) measures to improve social accountability and transparency, which shall be integrated into the

project design and consistent with the social mobilization thematic area in component one of the project, including ensuring that project reports are available to the public.

65. **Implementation support plan.** As the overall FM risk rating of the project is substantial, implementation support of project FM will be performed at least twice a year. The implementation support of the project will closely monitor the FM aspects, and will include but not be limited to operation of DAs, evaluation of the quality of budgets, project financial monitoring and management reviews of financial reports, quality of IFRs, relevancy of the FM Manual, internal controls, work and document flow and quality of financial records, and follow up of audit and mission findings. The review will also conduct random reviews of the statements of expenditures, and compliance with covenants. Based on implementation support results, the risk will be reassessed and the frequency of supervision recalibrated.

66. Measures to mitigate the late/non-submission of reports have been agreed upon during the appraisal stage.

67. **Financial Management Action Plan.** Table 3.2 below shows the FM action plan for the project.

Table 3.2. Agreed FM Action Plan

	Action	Date Due By	By Whom
1	Appointment/recruitment of officers (the accountants and finance assistant)	Date of effectiveness	IHPAU
2	Refresher course/training of Project Implementation Unit finance team on the Bank FM and disbursement procedures	During Project Implementation	IHPAU
3	Preparation of the Project Implementation Manual incorporating the FM policies and procedures.	Date of effectiveness	IHPAU
4	Acquisition and installation of computerized accounting software	Date of effectiveness	IHPAU

68. **Conclusion.** The conclusion of the assessment is that the FM systems of the IHPAU meet the Bank's minimum requirements for the administration of projects funds under OP/BP 10.00. The overall FM residual risk of the project is Substantial.

Procurement

69. The GoSL has enacted a Public Procurement Act (2004, amended 2015), which incorporates many features that meet international best practices in public procurement. An NPPA was created to manage the public procurement function. It sets policy, creates regulations, and monitors the implementation of Procurement Plans within the ministries and agencies of the government. The NPPA has significantly advanced the reform of the national public procurement system, for example, by creating regulations, SBDs and requests for proposals, and user manuals to implement the PPA. Subsequently, pursuant to the PPA, an Independent Procurement Review

Panel was created and has passed and published various judgments on cases referred to it by aggrieved bidders.

70. **Applicable guidelines.** Procurement under the project will be carried out in accordance with (a) 'Guidelines: Procurement of Goods, Works, and Non-Consulting Services Under IBRD Loans and IDA Credits & Grants by World Bank Borrowers' dated January 2011 and revised in July 2014; (b) 'Guidelines: Selection and Employment of Consultants Under IBRD Loans and IDA Credits & Grants by World Bank Borrowers' dated January 2011 and revised in July 2014; (c) 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants' dated October 15, 2006, and revised in January, 2011; and (d) the provisions methods stipulated in the Financing Agreement.

71. **Exceptions to National Competitive Bidding procedures.** The procurement procedure to be followed for National Competitive Bidding (NCB) shall be the open competitive bidding procedure set forth in The Public Procurement Act, 2015, of Sierra Leone (the Act); provided, however, that such procedure shall be subject to the provisions of Section I, and paragraphs 3.3 and 3.4 of the 'Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers', and the following additional provisions (exceptions to the Act):

(a) Bidding documents acceptable to the Bank shall be used.

(b) Eligibility to participate in a procurement process and to be awarded a Bank-financed contract shall be as defined under Section I of the Procurement Guidelines; accordingly, no bidder or potential bidder shall be declared ineligible for contracts financed by the Association for reasons other than those provided in Section I of the Procurement Guidelines. Foreign bidders shall be allowed to participate in NCB procedures, and foreign bidders shall not be obligated to partner with local bidders to participate in a procurement process.

(c) Bidding shall not be restricted to pre-registered firms, and foreign bidders shall not be required to be registered with local authorities as a prerequisite for submitting bids.

(d) No margins of preference of any sort (for example, on the basis of bidder nationality, origin of goods, services or labor, and/or preferential programs) shall be applied in the bid evaluation.

(e) Joint venture or consortium partners shall be jointly and severally liable for their obligations. Bidders shall be given at least 30 days from the date of publication of the invitation to bid or the date of availability of the bidding documents, whichever is later, to prepare and submit bids. Bids shall be submitted in a single envelope.

(f) An extension of bid validity, if justified by exceptional circumstances, may be requested in writing from all bidders before the original bid validity expiration date, if such extension shall cover only the minimum period required to complete the evaluation and award a contract, but not to exceed 30 days. No further extensions shall be requested without the prior written concurrence of the Bank.

(g) All bids (or the sole bid if only one bid is received) shall not be rejected, the procurement process shall not be cancelled, and new bids shall not be solicited without the Bank's prior written concurrence.

(h) Qualification criteria shall be applied on a pass or fail basis.

(i) Bidders shall be given at least 28 days from the receipt of notification of award to submit performance securities.

(j) In accordance with the Procurement Guidelines, each bidding document and contract shall include provisions stating the Bank's policy to sanction firms or individuals found to have engaged in fraud and corruption as set forth in the Procurement Guidelines.

(k) In accordance with the Procurement Guidelines, each bidding document and contract shall include provisions stating the Bank's policy with respect to inspection and audit of accounts, records, and other documents relating to the submission of bids and contract performance.

72. **Procurement documents.** The procurement will be carried out using the latest Bank's (SBDs) or standard request for proposal respectively for all international competitive bidding (ICB) for goods and non-consulting services and recruitment of consultants. For NCB, the recipient shall submit a sample form of bidding documents for the Bank's prior review after incorporating the exceptions listed above and will use this type of document throughout the project once agreed upon. The Sample Form of Evaluation Reports, developed by the Bank, will be used. NCB SBD will be updated to include clauses related to fraud and corruption, conflict of interest, Bank's inspection and auditing rights, and eligibility requirements consistently with the Bank Procurement Guidelines dated January 2011 and revised in July 2014.

73. Advertising procedure. The General Procurement Notice, Specific Procurement Notices (SPNs), Requests for Expression of Interest, and the results of the evaluation and contract awards should be published in accordance with the advertising provisions in the Bank procurement guidelines: (a) the General Procurement Notice will be prepared and published in United Nations Development Business (UNDB) online, on the Bank's external website, and in at least one national newspaper after the project is approved by the Bank Board and/or before project effectiveness; (b) SPNs for all goods and works to be procured under ICB and Requests for Expressions of Interest for all consulting services to cost the equivalent of US$300,000 and above will also be published in the UNDB online, the Bank's external website, and the national press; and (c) for works and goods using NCB procedures, the SPN will only be published nationally. The borrower will keep a list of received responses from potential bidders interested in the contracts.

Procurement Methods

74. **Works.** Contracts of works estimated to cost US$5,000,000 equivalent or more per contract shall be procured through ICB. Contracts estimated to cost less than US$5,000,000 but more than US$400,000 equivalent may be procured through NCB. Relevant NCB works contracts, which are deemed complex and/or have significant risk levels, will be prior-reviewed. Such

contracts will be identified in the procurement plans. For NCB, National Standard Tender Documents satisfactory to the Bank will be used.

75. Contracts estimated to cost less than US$400,000 equivalent per contract may be procured using shopping procedures in accordance with paragraph 3.5 of the Bank Procurement Guidelines. For shopping, procedures will be based on a model request for quotations satisfactory to the Bank. Contracts will be awarded following evaluation of bids received in writing on the basis of written solicitation issued to several qualified suppliers (at least three). The award will be made to the supplier with the lowest price, only after comparing a minimum of three quotations open at the same time, provided he has the experience and resources to execute the contract successfully.

76. To the extent possible and practical, work orders shall be grouped into larger contracts wherever possible to achieve greater economy and present interest for the bidders, at the procuring entity level. Also, works that are implemented in a district by different implementing entities could be combined into one procurement to provide greater economy and attract the bidders. Direct contracting may be used in exceptional circumstances with the prior approval of the Bank, in accordance with paragraphs 3.7 and 3.8 of the Procurement Guidelines.

77. For shopping, the project procurement officer will keep a register of suppliers updated at least every six months.

78. **Goods and non-consultancy services.** Goods procured under this project will include equipment and office furniture. Non-consultancy services procured under this project will include payment health facilities, workshops, and training in the region and abroad. Contracts for goods estimated to cost US$500,000 equivalent or more per contract shall be procured through ICB, using Bank's SBDs. To the extent possible and practicable, goods orders shall be grouped into larger contracts wherever possible to achieve greater economy, at the procuring entity level. In this regard, goods that cut across all implementing districts and/or other agencies will be managed at the central level by the IHPAU. Contracts estimated to cost less than US$500,000 but equal to or above US$200,000 equivalent per contract may be procured through NCB using the National Standard Tender Documents satisfactory to the Bank. Contracts estimated to cost less than US$200,000 equivalent per contract may be procured using shopping procedures in accordance with paragraph 3.5 of the Procurement Guidelines. For NCB, National Standard Tender Documents satisfactory to the Bank will be used, while shopping procedures will be based on a model request for quotations satisfactory to the Bank. Shopping consists of the comparison of at least three price quotations. At the minimum, this could be achieved by soliciting quotations through written invitations from not less than three qualified contractors. Direct contracting may be used in exceptional circumstances with the prior approval of the Bank, in accordance with paragraphs 3.7 and 3.8 of the Procurement Guidelines.

79. UN agencies and direct contracting may be used where necessary if agreed in the procurement plan in accordance with the provisions of paragraph 3.7 to 3.8 and 3.10 of the Procurement Guidelines. The following additional methods may be used where appropriate: Performance Based Procurement and Community Participation in Procurement.

80. **Consultant services.** Consultancy services will include various advisory services, studies, training, and technical assistance. For firms, selection method for consulting firms will include

Quality- and Cost-Based Selection (QCBS), Quality-Based Selection (QBS), Selection under a Fixed Budget (FBS), Least-Cost Selection (LCS), Selection Based on the Consultants' Qualifications, and Single-Source Selection (SSS) as appropriate. Contracts for consulting services will generally be procured through QCBS method. However, depending on the complexity and cost of the assignment, other selection methods could be used. Procedure of QBS will be followed for assignments that meet the requirements of paragraph 3.2 of the Consultant Guidelines; procedure of FBS will be followed for assignments that meet the requirements of paragraph 3.5 of the Consultant Guidelines; and procedure of SSS will be followed for assignments that meet the requirements of paragraphs 3.8–3.11 of the Consultant Guidelines and will always require the Bank's prior review regardless of the estimated cost. Consulting services estimated to cost less than US$300,000 per contract under this project may be procured following the procedures of Selection Based on Consultants' Qualifications. LCS will be used for assignments for selecting the auditors and for other assignments of a standard or routine nature and will be followed in accordance with paragraph 3.6 of the Consultant Guidelines. For all contracts to be awarded following QCBS, QBS, LCS, and FBS, the Bank's Standard Request for Proposals will be used. Selection of consulting firms will include launching a Request for Expressions of Interest, preparing short lists and issuing a Request for Proposal using the Bank' standard formats, when and as required by the Bank's guidelines.

81. For individuals, procedures of Selection of Individual Consultants (IC) will be followed for assignments which meet the requirements Section V of the Consultant Guidelines.

82. **Training, workshops, seminars, and conferences.** Training activities will comprise workshops and training in the region and abroad, based on individual needs as well as group requirements; on-the-job training; and hiring consultants for developing training materials and conducting training. All training and workshop activities will be carried out on the basis of approved annual programs that will identify the general framework of training activities for the year, including (a) the type of training or workshop envisaged; (b) the personnel to be trained; (c) the selection methods of institutions or individual conducting such training; (e) the duration of the proposed training; and (f) the cost estimate of the training. Attendance at relevant project workshops and seminars will be treated as training and will need the Bank's 'no objection' in advance of the training. Trainee(s) reports, including completion certificate/diploma upon completion of training, shall be provided to the project coordinator and will be kept as parts of the records and will be shared with the Bank if required.

83. **Operating costs.** Operating costs are incremental expenses arising under the project and based on the AWPBs approved by the Bank pursuant to the Financing Agreements. The operating costs will include reasonable expenditures for office supplies, vehicle operation and maintenance, communication and insurance costs, banking charges, rental expenses, office and office equipment maintenance, utilities, document duplication/printing, consumables, travel cost and per diem for project staff for travel linked to the implementation of the project, and salaries of contractual staff for the project, but excluding salaries of officials of the recipient's civil service, meeting and other sitting allowances, and honoraria to said staff. The procedures for managing these expenditures will be governed by the recipient's own administrative procedures, acceptable to the Bank.

Procurement Implementation Arrangements

84. **Project oversight.** The MoHS and health sector procurement is managed by the NPPU for drugs and medical supplies and the IHPAU for non-health items for donor funded projects. The NPPU, together with the DDMS, is responsible for procuring, storing, and distributing all drugs and medical supplies to all public health facilities throughout the country. The NPPU does procurement using donor funds and is responsible for the supply chain management of these goods, ensuring that the goods reach the intended beneficiaries.

85. The MoHS is responsible for procuring non-health products using both donor and government funds. The transaction costs associated with managing multiple donor funds separately, through different uncoordinated structures, have led to the establishment within the MoHS of the IHPAU in the Office of the Permanent Secretary. The IHPAU working alongside the DSS intends to integrate all donor-funded projects to be centrally managed by one coherent unit that integrated within the MoHS structure. The integrated projects are funded by the Bank, GAVI, the Global Fund, AfDB, UK Aid, the European Union, UN agencies, and others. The IHPAU is responsible for ensuring quality FM, timely procurement of supplies, and efficient monitoring, accountability and learning on all donor-funded projects.

86. **Assessment of the procurement unit capacity to implement procurement.** The procurement under the HSDSSP will be implemented by the MoHS through the IHPAU. Currently, the implementing agency has one procurement specialist and the recruitment of two procurement officers is underway. The procurement specialist has a master degree in public procurement and experience in procurement procedures of different development partners and NGOs but with less experience in the Bank and national procurement procedures. The MoHS procurement team will do a handholding in the implementation of the project and have an experienced team, but they are new to the ministry and have no experience in procurement of medical related equipment and pharmaceuticals.

87. **Assessment of risks and mitigation measures.** An assessment of the existing procurement unit capacity to implement procurement activities for the project was carried out. The assessment reviewed the internal arrangements for handling procurement, the organizational structure for implementing the project, and the capacity of staff responsible for procurement activities under the proposed project. The assessment also reviewed the interaction between the project staff responsible for procurement and the new structures that implemented the new procurement code.

88. The procurement risk is considered to be Substantial for several reasons. First, as the IHPAU is currently being established, it has limited capacity to handle the project procurement activities; staff are few and lack necessary qualifications and experience, and there is a risk that the required procurement skills will not be found during the recruitment process. Second, an organizational structure and mechanisms for evaluating tenders, awarding contracts, and managing execution and payment are not sufficiently developed. As risk mitigation measures, capacity building will be required for the procurement team on the Bank procurement procedures, and technical assistance will be recruited to assist the procurement team until it is able to handle procurement processes. Procurement internal control mechanisms in line with NPPA regulations

will be established and should include at least a procurement unit, an evaluation committee and a review committee on large tenders above a threshold that will be discussed and agreed upon.

89. The MoHS will set up an ad hoc technical evaluation committee composed of subject matter specialists drawn from the ministry and IHPAU who will be responsible for evaluation of tenders and recommendation of award. The technical evaluation committee may seek assistance from a specialist in evaluation of tenders where they do not have required technical skills. The MoHS will establish a procurement committee under the IHPAU for a specific period of time with a mandate of reviewing evaluation and making recommendations of award to management based on the report of the technical evaluation committee.

90. Schedule of Risk Mitigation Action Plan to be carried out is provided in table 3.3**.**

Table 3.3. Procurement Risk Mitigation Action Plan

	Action	Responsibility	Due Date	Remarks
1	Recruitment of procurement officers	MoHS	By effectiveness	To manage procurement processes
2	Formation of tender evaluation and review committees	MoHS	During project implementation	To evaluate and recommend award of tenders
3	Training of staff (at least two) on Bank procurement procedures in specialized institutions	MoHS	During project implementation	To improve staff skills in Bank procurement procedures

Procurement Review Requirements and Methods

91. **Procurement Plan.** There is no Procurement Plan in place at present, and the project will be required to prepare an 18-month Procurement Plan and submit it to the Bank for approval before signature of the Financing Agreement. For each contract, the Procurement Plan will define the appropriate procurement methods or consultant selection methods, the need for pre-qualification, estimated costs, the prior-review requirements, and the time frame. The Procurement Plan will be updated at least annually, or as required, to reflect the actual project implementation needs and capacity improvements. All procurement activities will be carried out in accordance with approved original or updated procurement plans. All Procurement Plans should be published on the Bank website according to the guidelines.

92. **Procurement prior-review thresholds.** Prior-review thresholds are tied to the substantial procurement risk (shown in table 3.4) and reflected in the Procurement Plan.

Table 3.4. Procurement Prior-Review Thresholds

No	Expenditure Category	Contract Value Threshold (US$)	Procurement Method	Contracts Subject to Prior Review (US$)
1	Works	≥ 5,000,000	ICB	All contracts
		< 5,000,000	NCB	Each contract of value equal or above US$5,000,000 equivalent

		≤ 200,000	Shopping	None
		All values	Direct contracting	All contracts
2	Goods and services (other than consulting services)	≥ 500,000	ICB	All contracts
		< 500,000	NCB	Each contract of value equal or above US$500,000 equivalent.
		< 100,000	Shopping	None
		All values	Direct contracting	All contracts
3	IT systems, and non-consulting services	≥ 500,000	ICB	Each contract of value equal or above US$500,000 equivalent
		< 500,000	NCB	Each contract of value equal or above US$5,000,000 equivalent
4	Consulting services	≥ 200,000 firms	All	All contracts
		< 200,000	All	Only TORs
		≥ 100,000 individuals	IC	All contracts
		< 100,000 individuals	IC	TORs
		All values	SSS	All contracts
5	Training, workshops, study tours Community participation in procurement acceptable to the Association and described in the PIM	All values	To be based on AWPBs and training plan	

93. **Frequency of procurement supervision.** In addition to the prior review that will be carried out by the Bank, the procurement capacity assessment has recommended two supervision missions each year. IDA will carry out sample post review of contracts that are below the prior-review threshold for contracts implemented to ascertain compliance with the procurement procedures as defined in the legal documents. The procurement post reviews should cover at least 15 percent of contracts subject to post review, as the risk rating is Substantial.

94. **Contracts disbursements status reports**. As part of the project reports, the MoHS will submit contract management and expenditure information in quarterly reports to the Bank. The procurement management report will consist of information on procurement of goods, works, non-consulting and consulting services, and compliance with agreed procurement methods and requirements. The report will compare procurement performance against the plan agreed at negotiations and, as appropriate, revised during the project implementation. The report will also provide any information on complaints by bidders, unsatisfactory performance by contractors, and any information on contractual disputes.

95. **Procurement audit.** A procurement audit will be carried out at least every year during project implementation and report on the procurement process, contract management, fiduciary compliance, and so forth.

96. **Procurement information and documentation.** Procurement information will be recorded and reported as follows: (a) complete procurement documentation for each contract, including bidding documents, advertisements, bids received, bid evaluations, letters of acceptance, contract agreements, securities, related correspondence, and so on, will be maintained at the level of respective ministries in an orderly manner, readily available for audit; (b) contract award information will be promptly recorded and contract rosters as agreed will be maintained; (c) comprehensive quarterly reports indicating (i) revised cost estimates, where applicable, for each contract; (ii) status of ongoing procurement, including a comparison of originally planned and actual dates of the procurement actions, preparation of bidding documents, advertising, bidding, evaluation, contract award, and completion time for each contract; and (iii) updated procurement plans, including revised dates, where applicable, for all procurement actions.

97. **Publications of awards and debriefing.** For ICB and Request for Proposals that involve international consultants, the contract awards shall be published in the UNDB online within two weeks of receiving IDA's 'no objection' to the recommendation of the contract award. For goods, the information to publish shall specify (a) the name of each bidder who submitted a bid; (b) bid prices as read out at bid opening; (c) the name and evaluated prices of each bid that was evaluated; (d) the name of bidders whose bids were rejected and the reasons for their rejection; and (e) the name of the winning bidder and the price it offered, as well as the duration and summary scope of the contract awarded. For consultants, the following information must be published: (a) names of all consultants who submitted proposals; (b) technical points assigned to each consultant; (c) evaluated prices of each consultant; (d) final point ranking of the consultants; and (e) the name of the winning consultant and the price, duration, and summary scope of the contract. The same information will be sent to all consultants who submitted proposals. The other contracts should be published in national gazette periodically (at least quarterly) and in the format of a summary table covering the previous period with the following information: (a) the name of the consultant to whom the contract was awarded; (b) the price; (c) duration; and (d) scope of the contract.

98. **Fraud and corruption**. All procurement entities as well as bidders and service providers (that is, suppliers, service providers, and consultants) shall observe the highest standard of ethics during the procurement and execution of contracts financed under the project in accordance with paragraphs 1.16 and 1.17 (Fraud and Corruption) of the Procurement Guidelines and paragraph 1.23 and 1.24 (Fraud and Corruption) of the Consultants Guidelines, and the 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants', dated October 15, 2006, and revised in January 2011, in addition to the relevant Articles of the Sierra Leone Public Procurement Act 2015.

99. **Anti-fraud and anticorruption measure.** The anticorruption requirements are included in all Bank Standard Bid Documents and Contracts for Goods, Works, and Consultants' Services. The task team will also ensure that equivalent provisions are included in any bid documents and contracts used for NCB and shopping. In addition, the task team will maintain intensive oversight and will carry out prior review of all major contracts according to the thresholds that will be regularly reviewed and adjusted as needed in the Procurement Plan. The following additional measures will be taken to mitigate fraud and corruption risks:

(a) Training of Recipient's fiduciary staff starting from the project launch, repeated periodically thereafter, and supplemented by on the job training on procedures and methods required to effectively carry out their due diligence function;

(b) Employment by the recipient of reputable agents to carry out technical audits under the project;

(c) Include a detailed Work and Contract Management Plan in the Project Implementation Manual, based on verifiable information, to be implemented by the Procurement Consultant as a task included in its TOR;

(d) Complaints: Establish, implement, and maintain an effective method and procedures for the Ministry of Education, Sciences and Technology (MEST) to address and resolve in a timely manner complaints received from bidders. Notice on the availability of a complaint methodology including simple instructions on how to file a complaint shall be displayed publicly in the Notice Board of the MEST and LCs; and

(e) Transparency: A public information system will be established by the MEST and LCs. Information on public procurement under the project will be published and distributed through available media, including through a project's website with free national and international access. Information published will include at least invitations to prequalify, bid, or express interest as required by paragraphs 2.7–2.10 of the Procurement Guidelines and paragraph 2.5 of the Consultants Guidelines.

Environmental and Social (including Safeguards)

100. The Bank has supported a number of projects in the health sector, and these projects have addressed concerns over the management of health care waste and the environmental impact of construction work. The Environmental Protection Agency, established in 2008 to create and enforce the framework for environmental regulation, has acquired broad knowledge of the Bank's safeguard policies and requirements and has been collaborating with the Bank on capacity programs for safeguards.

101. The project's activities will not include large scale construction, but minor civil works have been proposed for the rehabilitation and expansion of selected health facilities, primarily at the PHU level. Consequently, the project is unlikely to harm the environment. However, since project activities are expected to increase the use of health services, the project is likely to increase the generation of biomedical waste. While these consequences are not expected to have long-term detrimental or cumulative effects, the project is classified as Category B.

102. The project will not have a negative social impact, since it will not finance any activities necessitating involuntary land acquisition resulting in: (a) the involuntary resettlement of people and/or loss of (or access to) assets, means of livelihoods or resources; or (b) the involuntary restriction of access to legally designated parks and protected areas resulting in adverse impacts on the livelihoods of the displaced persons.

103. Rather, the project will have a positive social impact on communities and on particular groups in these communities. (a) Communities will benefit from the recruitment of CHWs and the range of essential services intended to rebuild the trust of the community into the public health system; (b) Within the communities, the poorest households will benefit from increased access to health services; and (c) Within households, pregnant women and children will benefit from the BEPHS and the possibilities of transportation to referral facilities.

104. Within the MoHS, the DEHS, with consultant assistance (where necessary), will determine and prepare appropriate instruments for mitigating environmental and social safeguards impacts identified during project implementation. The ESMF prepared for the EERP has been updated, along with the Matrix of Mitigation measures for potential environmental impacts.

Monitoring and Evaluation

105. The PDO indicators and key intermediate outcome indicators were agreed on with the MoHS and its development partners. By aligning the indicators used by the MoHS and its partners, the project aims to increase ownership of the selected indicators and strengthen the existing (and proposed) M&E systems. Selection of the indicators was based on consideration of (a) the project's 2½-year duration; (b) the proposed subcomponent support; and (c) the availability of baseline and monitoring data from the MoHS' routine, but very limited, HMIS or from planned surveys. The Results Framework and M&E arrangements are described in annex 1.

106. The outcome indicators were selected from available data sources and used results from 2013 as the baseline because (a) they constitute the last full year for results before the Ebola outbreak and (b) because it is possible to compare DHS results with those of the national HMIS. Although dates for the next DHS are not known, two other sources may be available: (a) the Sierra Leone Integrated Household Survey,[66] planned for 2016–17, will incorporate questions addressing the outcome indicators and (b) a Multi-Indicator Cluster Survey should be conducted in 2017–18.

107. The intermediate outcome indicators also rely on data that are expected to be regularly available from (a) CHW Program monitoring; (b) public health checklists for the PHAs; (c) annual facility surveys and scorecards (for emergency obstetric and newborn care); (d) national ambulance service data; (e) training program information; and (f) Planning Directorate information (SLA, annual reviews, and so on). For these indicators, baselines will be established during the initial six months of the project as the indicators are rolled out.

108. The DPI and IPHAU will be responsible for producing regular reports on the results. The Planning Directorate is responsible for the HMIS data and will ensure that the results are collected regularly by health facilities, submitted in a complete and timely manner to districts, and aggregated nationally by the directorate. The IPHAU will work closely with the Directorate of Financial Resources and DPI to prepare comprehensive financial and program information. Financial data are expected to be available within 45 days of the completion of the funding period while program information is expected to be available within 90 days of the end of each quarter.

[66] The DHS provides baseline data for 2013, the full year before the Ebola epidemic; the Sierra Leone Household Integrate Survey team has agreed to include project outcome indicators and will provide either midterm or final results depending on the timing of the survey.

109. The project will support efforts to improve data collection and analysis at the central, district, and community levels. In addition, resources are available for selected studies and evaluations. Given the short duration of the project, a midterm review is not planned. The project will however support (a) annual program reviews and (b) annual district planning exercises, which will enable the central and district levels to analyze experience and incorporate the results into future plans.

110. Given the demonstrated effects of the epidemic on the utilization of health services, the project has opted to establish modest targets for the outcome indicator targets rather than establish new baseline data. This will require a careful analysis of existing HMIS data and intensive support to strengthen the HMIS at all levels. Attribution of results to the project will be limited to those interventions financed in large measure by the project: the ambulance services, the clinical residency training, and the SLA. CHW data will be disaggregated by district to allow for comparisons among districts and with the national results, but the presence of multiple partners supporting the program will preclude attribution of the results to the project

Annex 4: Implementation Support Plan

SIERRA LEONE: Health Service Delivery and System Support Project

Strategy and Approach for Implementation Support

1. The Implementation Support Plan focuses on mitigating the risks identified in the SORT and aims at making implementation support to the client more flexible and efficient. It also seeks to provide the technical advice necessary to facilitate achievement of the PDO (linked to results/outcomes identified in the Result Framework), as well as identify the minimum requirements to meet the Bank's fiduciary obligations.

- **Technical.** Implementation support will include (a) progress on objectives, (b) fine-tuning of strategies where required, and (c) drawing of lessons from the implementation for wider applicability.

- **Financial management.** Implementation support will include (a) reviewing submitted reports and providing timely feedback to the implementing agency; (b) supporting the development of the internal audit function within the MoHS; and (c) providing training and support to the accountants within the Office of Administration and Finance.

- **Procurement.** Implementation support will include (a) providing additional staff and training as needed for the MoHS and the project team; (b) reviewing procurement documents and providing timely feedback to the MoHS and the project team; (c) providing detailed guidance on the Bank's Procurement Guidelines to the MoHS and the project team; and (d) monitoring procurement progress against the detailed Procurement Plan.

- **Environmental and social safeguards.** The Bank team will supervise the implementation of the agreed ESMFs and plans and provide guidance to the MoHS and project teams to ensure that safeguards issues are addressed.

- **Other issues.** Sector-level risks will be addressed through policy dialogue with the relevant government ministries.

Implementation Support Plan

2. The Bank team members will be based in Washington, D.C., in the Sierra Leone Country Office in Freetown, and in other country offices and will be available to provide timely, efficient, and effective implementation support to the clients. Formal supervision and field visits will be carried out at least twice annually. These will be complemented with regular video conferences to discuss project progress. Detailed inputs from the Bank team are outlined below:

- **Technical, policy, and legal/regulatory inputs.** Technical, policy, and legal/regulatory-related inputs will be required to review bid documents to ensure fair

competition, sound technical specifications and standards, and that activities are in line with the government's health sector strategies.

- **Fiduciary requirements and inputs.** Training will be provided by the Bank's FM and procurement specialists as needed. The Bank team will also help identify capacity-building needs to strengthen FM capacity and to improve procurement management efficiency. FM and procurement specialists will be based in the country office to provide timely support. Formal supervision of FM and procurement will be carried out semiannually.

- **Safeguards.** Inputs from environment and social development specialists will be provided as needed.

- **Operation.** The task team will provide day-to-day supervision of all operational aspects, as well as coordination with the clients and among Bank team members. Relevant specialists will be identified as needed.

Table 4.1. Implementation Support Plan

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First 12 months	Capacity building	Technical experts (including HSS, HRH, health/economic/financing, health planning and implementation, supply chain and pharmaceuticals, communications, governance)		
	Capacity building on FM, procurement, and internal audit	FM and procurement staff and consultants		
	Capacity building on M&E	Project Implementation Unit and Bank staff or experts in M&E		
12–48 months	Implementation support	Same as above		

Note: HSS = Health systems strengthening; HRH = Health Human Resources.

Table 4.2. Skills Mix Required

Skills Needed	Number of Staff Weeks (Annually)	Number of Trips	Comments
Task team leader	10	As required	Washington, D.C. based
Procurement	5	idem	Country office based
FM specialist	5	idem	Country office based
Health specialist	40	idem	Country office based
Environment specialist	2	idem	Washington, D.C. based
M&E specialist	4	idem	Washington, D.C. based
Health financing specialist	5	idem	Washington, D.C. based
Economist	4	idem	Washington, D.C. based
Governance specialist	1	idem	Country office based
Social development/safeguards specialist	2	idem	Country office based

Annex 5: Financial and Economic Analysis

1. **Coming in the aftermath of the Ebola crisis, the importance of investing in strengthened health systems is immediately apparent.** First, with its immediate disruption of lives, livelihoods, and businesses, the linkage between health and macroeconomic performance has been clearly demonstrated. Second, the response to the epidemic has confirmed the importance of public health sector investment on (a) high-impact and cost-effective interventions to produce important positive externalities with limited resources and (b) financial risk protection afforded to those who might otherwise have faced extreme economic hardship as a result of ill health. Third, public investment in the health of the poor, particularly women and children, has been shown to contribute to economic and social growth and development and constitutes a prerequisite for reducing poverty.

2. Public interventions are usually justified, from an economic perspective, under two conditions: (a) the first one is that there are proved market failures and (b) the second is that interventions that could correct these failures without imposing additional costs on the taxpayers exist. These conditions are met in Sierra Leone. With an increased coverage of mothers and children, as well as a better quality of services provided to this target population, major savings in health expenditures can be expected both in the near, mid, and long term.

3. Increased coverage and improved quality will be furthered by the planned synergies of the EERP and HSDSSP. Together, the EERP's proposed restructuring and the HSDSSP's future support constitute a comprehensive and flexible response to the lasting effects of the epidemic and the need for the future development of Sierra Leone's health sector. As conceived, the EERP and HSDSSP will (a) share a common programmatic framework; (b) provide complementary financial inputs; and (c) use the same fiduciary arrangements. The following analysis, therefore, includes the financial resources and anticipated effects of both the restructured EERP[67] and the proposed HSDSSP.

4. **Two complementary analyses of the project's costs and benefits have been carried out.** Because the project emphasizes both health services delivery and health systems support, two analyses were conducted to estimate (a) the costs and benefits generated by the project's CHW approach[68] and (b) the costs and benefits of the project as a whole. The analysis included the cost from both the HSDSSP and EERP.

5. **Cost-benefit analysis of the CHW component**. Costs have been estimated for the period 2016–19 (the project is expected to last 3 years) and benefits for the CHW component are estimated for the period 2016–2020, under the minimal assumption that the program will continue to operate for one more year after the project closure. The costs have been estimated on the basis of the proposed HSDSSP (of April 7, 2016). Costs of 2017 and 2018 have been discounted at a rate of 3

[67] The original PAD for the EERP did not include an economic and financial analysis of the support to the government's Post-Ebola Health Services Delivery and System Support Plans; this analysis includes only the undisbursed funds from the EERP earmarked for this purpose in combination with those of the HSDSSP.
[68] These include the following subcomponents: CHW, MCDT, EMS, clinical residency training, and auxiliary health worker training.

percent (contrary to benefits, we have assumed that program costs were disbursed at the beginning of the year).

6. The main direct benefit derives from the economic value of lives saved and the cost savings for reduced risk factors for communicable diseases (mostly) and non-communicable diseases. Because of scarcity of data relating to DALYs, the Lives Saved Tool[69] is used to estimate the number of lives saved due to changes in coverage of reproductive, maternal, neonatal, and child health interventions in the selected districts.

7. In Sierra Leone, the CHW Program could save 16.35 lives per 100,000. Calculations are confirmed by the study from the WHO[70] on the cost-effectiveness of CHWs in MCH programs. This WHO study focuses on remote districts from Kenya and Ethiopia, very similar to those in Sierra Leone, in which the MCH services are provided by CHWs. Lives saved range from 6.05 per 100,000 in the Shebedino District of Ethiopia to 26.33 per 100,000 in the Kasanari District of Kenya.

8. The CHW component of the project will be implemented in the most hard-to-reach areas with a target population estimated at 589,097 in 2016; 602,137 in 2017; 615,465 in 2018; 629,088 in 2019; and 643,013 in 2020. This means that the estimated lives saved will be 96 in 2016; 98 in 2017; 101 in 2018; 103 in 2019; and 105 in 2020. Translated into LYS (for an estimated average of 29 years lost per death), this gives 2,793 LYS in 2016; 2,855 LYS in 2017; 2,918 LYS in 2018; 2,983 LYS in 2019; and 3,049 LYS in 2020.

Table 5.1. Main Data for the Cost-Benefit Analysis of the CHW Component

Year	Discounted Costs (US$)	Targeted Population	Life-years saved (LYS)	Benefits	Deflated CPI
2016	700,000	589,097	2,793	1,983,175	1,888,739
2017	1,553,398	602,137	2,855	2,027,073	1,838,615
2018	1,885,192	615,465	2,918	2,071,942	1,789,821
2019	1,830,283	629,088	2,983	2,117,804	1,742,322
2020	–	643,013	3,049	2,164,681	1,696,084

9. Valuing the life year at its minimum, that is, the gross national income per capita (estimated at the Atlas method) provided by the Bank, one obtains (a) a BCR of 1.50, which means US$1.50 in benefits can be expected for every US$1.00 spent on the CHW Program, and (b) an IRR of 15.58 percent. While not too sensitive to the deflator (consumer price index) and the discount rate, the results are more sensitive to the value attributed to lives saved (which is not uncommon). Both the BCR and the IRR validate the decision to implement the CHW Program on MCH in Sierra Leone.

[69] The Lives Saved Tool, Johns Hopkins, Bloomberg School of Public Health. The Lives Saved Tool models the impact of scaling up the coverage of proven interventions on maternal, neonatal, and child mortality by integrating evidence on intervention effectiveness and demographic projections of mortality.

[70] McPake et al. 2015. "Cost-Effectiveness of Community-Based Practitioner Programmes in Ethiopia, Indonesia, and Kenya." *Bulletin of the WHO* 93 (9).

10. **Cost-benefit analysis of the project**. As for the CHW component, project costs have been estimated for the period 2016–19 and project benefits have been estimated for the period 2016–20. The project's total cost is US$15.5 million, which has been estimated on the basis of the HSDSSP draft budget (of March 16, 2016) and approximately US$27 million from the EERP (of March 16, 2016). The main direct benefit derives from the DALYs averted, which results from the increased utilization and improved quality of essential MCH services in the hard-to-reach areas.

11. DALYs lost to communicable, maternal, perinatal, and nutritional conditions by mother and children have been estimated at 3,389,000 in Sierra Leone (see WHO gbddeathalycountryestimates). This represents a loss of 629 DALYs per 1,000 persons. For the population in the hard-to-reach areas and based on WHO estimates, this translates into losses of DALYs amounting to 20,602 in 2016; 18,538 in 2017; 18,754 in 2018; 15,836 in 2019; and 13,137 in 2020.

Table 5.2. Main Data for the Cost-Benefit Analysis of the Project

Year	Costs (US$)	Targeted Population	DALYs Lost to MCH Causes	DALYs Averted	Discounted Benefits
2016	11,000,000	410,488	1,391,142	20,602	13,931,120
2017	18,446,602	419,574	1,421,935	18,538	11,938,595
2018	7,540,767	428,861	1,453,409	18,754	11,502,297
2019	3,660,567	438,354	1,485,580	15,836	9,250,366
2020	–	448,057	1,518,463	13,137	7,307,917

12. With a valuation of a DALY at the gross national income per capita and a discount rate of 5 percent, the discounted benefits amount to US$53,930,295. The BCR is 1.33 and the IRR is 11.47 percent. Both the BCR and the IRR validate the decision to implement the HSDSSP in Sierra Leone. As could be expected, values for the project as a whole are lower than those for the CHW component, due to (a) the increased cost of the other project components (and especially Component 2 with significant training costs) and (b) the limited increase in benefits to the additional DALYs averted by the services delivered at the facility level by non-CHW (Subcomponent 2). As for the previous calculations based on lives saved, the IRR is highly sensitive to the value attributed to the DALYs.

13. **The immediate fiscal impact for the country is negligible.** Bank financing will be through (a) an IDA credit of US$10 million equivalent;[71] (b) a grant of US$5.5 million as part of the Ebola Emergency Trust Fund; and (c) the undisbursed EERP funds of approximately US$27 million.[72] GoSL financing for this project is negligible. The project being strategically focused as it supports activities that will reduce public health expenditures on mothers and children in the future, the midterm and long-term fiscal impact should be positive.

14. **The project is considered as sustainable.** Bank financing will be an IDA credit of US$10 million equivalent (to date the external debt stocks [in current US$] of Sierra Leone is US$1.4 billion, for a population of 6.5 million inhabitants). To this credit is added a grant of US$5.5 million as part of the Ebola Emergency Trust Fund. GoSL financing of this project is US$0. This

[71] To date the external debt stocks (in current US$) of Sierra Leone is US$1.4 billion, for a population of 6.5 million inhabitants.
[72] Undisbursed funds from the EERP have been estimated at US$27 million on February 15, 2016.

means that the immediate fiscal impact for the country is negligible. The project being strategically focused as it supports activities that will reduce public health expenditures on mothers and children in the future, the midterm and long-term fiscal impact should be positive.

15. However, with a very low public spending per capita of about US$6.5 (despite WHO's most recent recommendation of US$54) and despite the low cost of pursuing the project (after 2019), the GoSL will have to essentially finance in-service training, pay incentives to the CHW, and maintain the acquired equipment to keep the MCH coverage level reached at the end of the project. This can be estimated at an annual contribution of about US$4.2 million or US$0.65 per capita), and project sustainability might be an issue.[73]

16. The projected annual cost after 2019 will represent about 11 percent of the total public health spending (at the current level). Furthermore, the cost of the Health Strengthening Strategy has been estimated at US$892.6 million (with a financing gap of US$666.9 million) and interventions to restore basic health facilities at US$118.2 million (US$4 million paid by the GoSL and a financing gap of US$40 million).

17. Unless the government increases the share of the health budget currently at about 10.5 percent to the 15 percent of the Abuja declaration, Sierra Leone will still need to be heavily supported by the donor community to run its health activities, including those of this project. However, this increase will very likely not take place in the short term. Indeed, growth perspectives for 2015 and 2016 are not good. The GDP at constant price will decrease by 21.5 percent in 2015 and then increase by 0.1 percent in 2016 before reaching pre-Ebola growth rates, with 19.6 percent in 2017 and 17.5 percent in 2018.[74] This means that it will take at least three years before the GoSL can increase the health budget. Furthermore, as noted in a recent Bank-financed fiscal space analysis of the health sector in Sierra Leone (see footnote 4), "it would be unethical to argue for increased government funding of the health sector if the resources are not used either efficiently or equitably." Policies and programs aiming at fixing the numerous inefficiencies (such as fragmented payment system, illegal fees, pharmaceuticals, and supplies procurement) will also need to be financed.

[73] Also, assuming that 70 percent of the cost of ambulance emergency services is required to cover MCH emergency transportation needs, an additional US$546,000 per year would be needed, totaling US$4.55 million or US$0.70 per capita.

[74] Jibao, Samuel S. 2015. *Fiscal Space Analysis for Health Strengthening in Sierra Leone.* Washington, DC: World Bank.

Annex 6: Alignment of Bank and other Partner Support for the Key Health Initiatives in Sierra Leone's Post-Ebola HSS Plan

Priority Areas/Activities	Bank Support	Other Major Partner Support
Community-level engagement		
Community outreach (including support to the CHW Program)	**EERP**: Support to 3 districts (Bo, Bombali, Kenema)	**UNICEF:** Technical support to policy revision; national coordination of the CHW Program **Global Fund:** Supporting the CHW Program
	HSDSSP and ERRTF: Continue 3 EERP districts as well as 1 district (TBD)	**DFID**: CHW Program support (through IPs in selected districts)
	REDISSE: Potential support for community-level surveillance	**USAID:** May support CHWs in the five targeted districts (Bombali, WAR, WAU, Port Loko, Tonkolili)
		AfDB: Strengthening civil society/communities' response to the epidemic
Environmental health/Regulation (support to the ESICOME)	**HSDSSP and ERRTF**: Strengthen/implement environmental regulation and train staff	**DFID**: Technical support to the DEHS
Facility-level services		
BEmONC and CEmONC (Basic and Comprehensive emergency obstetric and neonatal care) and referral support	**EERP:** Comprehensive support to 11 facilities (UNFPA); targeted support to facilities (UNOPS)	**DFID:** Co-financing the EERP in facilities upgrade (through UNOPS); renovation/rehabilitation of facilities (focus on WASH and IPC)
		USAID: Rehabilitation of PHUs in 5 districts
		UNICEF and WHO: Periodic assessment of facility capabilities
		JICA: BEmONC upgrade of 3/4 CHCs (through UNICEF and UNFPA); institutionalization of IPC at the DHMT level and for selected hospital/CHC levels in 4 districts
MDCT deployment, facility rehabilitation, equipment	**EERP:** Support first 2 years	**JICA:** Providing one foreign pediatrician/pediatric nurse in a tertiary hospital (potentially Ola During Hospital)
	HSDSSP and ERRTF: Continue EERP support	
	REDISSE: May support rehabilitation of laboratories	
EMS	**EERP:** Technical design, depot works, initial staffing	**DFID:** Support for fleet management at the district level for (DFID-procured) vehicles; support for routine health and laboratory services
	HSDSSP and ERRTF: Operational support for rollout	
Support on drugs supplies	**EERP:** Emergency drugs supply (complete)	**USAID**: Support for supply chain management, e-LMIS
		USAID and DFID: Procurement of essential drugs (through UNICEF as a procurement agency)

Health human resources		
HR policy/strategy development		**Clinton (Clinton Health Action Initiative)/WHO/DFID:** Support to the MoHS payroll audit and national HRH policy/strategy
		WHO: Support revision for the HRH policy and strategic plan, health workers incentives
		DFID: Support to remote area allowances
		AfDB: Health worker safety
Clinical residency training	**EERP:** Initial staffing only	**WHO:** Technical support to COMAHS for postgraduate training
	HSDSSP and ERRTF: Comprehensive operational support	**DFID:** Teaching support for postgraduate training (through the U.K. Royal Colleges)
		China: Teaching support for postgraduate training
Auxiliary health worker training	**EERP:** Infrastructure design and development	
	HSDSSP and ERRTF: Operational support	
Sector coordination and management		
MOHS-level support	**EERP:** HSS Hub staffing and operation	**Global Fund**: Support to operational costs of the DPI
	HSDSSP and ERRTF: Continuation of HSS hub and other MoHS operations, HMIS, MDSR	**DFID:** HMIS **AfDB:** HMIS
DHMT-level support	**EERP:** Initial training, staff recruitment (HMO)	**DFID:** Operational, technical, capacity-building support to improve management (and supervision activities); HMIS
	HSDSSP and ERRTF: Capacity strengthening, HMIS	**WHO:** Technical guidance/framework for building the leadership and management capacity of DHMTs.
		JICA: Technical support to DHMT staff in monitoring and supervision in 4 districts (team of 4 Japanese experts posted at the DHMT to conduct joint supportive supervision visits) Global Fund: Support M&E function
SLA	**EERP:** Staffing and database	**WHO:** Technical Assistance (6 months), computers, office furniture
	HSDSSP and ERRTF: Continue EERP support	
Project management		
IHPAU	**EERP:** Initial staffing	**Global Fund and GAVI**: Co-financing IHPAU staffing/operations cost
	HSDSSP and ERRTF: Continue EERP support	

Epidemic preparedness and response		
Priority facility infrastructure - triage and isolation	**EERP:** 23 government hospitals (UNOPS)	**DFID:** Support for triage and isolation facilities
		AfDB: Refurbishment of isolation facilities
Regional surveillance support	**EERP:** Funds to the WHO for preparation of the REDISSE	**DFID:** Support for DHMTs on preparedness and resilience
	REDISSE: Main focus of the REDISSE along with national surveillance support	**AfDB**: Surveillance **Centers for Disease Control**: Surveillance support
		PHE: Laboratory and surveillance support
		WHO: Supporting IDSR

Annex 7: Citizen Engagement Measures

Context

1. With the objective of increasing the inclusiveness of the development process, the Bank strategy incorporates CE (including beneficiary feedback) as a means for (a) increasing citizen participation in the development process and (b) integrating citizen voice in the implementation of development programs. CE comprises successive levels of citizen involvement from information to consultation to collaboration, and ultimately to empowerment.

2. Within the context of Investment Project Financing, CE emphasizes the need for feedback from clearly identified (direct) project beneficiaries during all phases of the project: preparation, implementation, and evaluation. The objective is to integrate consultation, collaboration, and empowerment activities into the design and implementation of the project to facilitate continuous learning, improved project monitoring, and improved project outcomes.

Proposed Project Contributions to the Promotion of CE

3. In the context of the proposed project, CE and, more specifically, beneficiary feedback will be enhanced by (a) exchanges of information to ensure the continued relevance of the proposed program interventions to the needs of the community; (b) formal and informal consultation and collaborative decision making on the type and intensity of services delivered to the community; and (c) accountability for the quantity and quality of services received by the beneficiaries.

4. The project will support a variety of mechanisms to promote CE at three levels: district, facility, and community.

- At the district level, CE involves information, consultation, and collaboration through participatory planning and budgeting.

- At the facility level, CE comprises (a) information and consultation between higher-level health authorities and the facility and (b) collaboration on the functionality of the facility and any other matter affecting health service delivery and utilization within the catchment area.

- At the community level, CE is empowered by its involvement in (a) consultation and collaboration in the selection of the CHW and (b) participation in the periodic assessment of the CHW's performance.

5. **At the level of the health district, the project will support CE through the following:**

- **Semiannual reviews of the implementation of SLAs.** Held at the district level and coordinated by the MoHS (SLA secretariat), these consultations involve local authorities and civil society organizations responsible for providing services within selected communities. SLAs are agreements signed by the IP, the DHMT, and the LC. The project is financing semiannual meetings, coordinated by the MoHS SLA secretariat at the district level to discuss the implementation and results of the SLA.

Quarterly reports will be made available and funding has been provided for the distribution of the results of the quarterly bulletins to the relevant parties.

- **Annual/semiannual health district reviews.** Through information exchange, consultation, and collaboration, these periodic reviews will (a) involve the DHMT and civil society representatives (LCs, VDCs,[75] FMCs,[76] and so on) in participatory planning and implementation monitoring and (b) aim to include the different points of view.

6. **At the level of the health facility.** FMCs have been created at more than 1,100 PHUs. They are intended to ensure that health workers are accountable to the communities they serve. FMCs are expected to (a) participate in translating health policies and initiatives to communities; (b) work with facility staff to ensure that services are of the highest quality; (c) monitor activity in the health facility (with checklists provided by the MoHS); and (d) inform health workers of the community's satisfaction with services delivered and (where noted) report irregularities and breaches in service delivery directly through the toll-free phone line provided.

7. **At the level of the community.** CHWs are (a) selected jointly by the community and local officials (health and non-health); (b) supervised by trained peers and the PHU; and (c) evaluated annually on the basis of objective and transparent criteria by technical program staff and community beneficiaries. Accountability of the CHW to the beneficiary community is therefore ensured from several perspectives: local, district, and national.

Proposed CE Indicator

8. Indicators could be selected for any of the four contributions to CE, but the project has determined that the community level, as embodied by the CHW, is probably the most appropriate for best capturing beneficiary feedback. Given the intersection of CE issues at the level of the CHW, the following indicator is for monitoring engagement:

- Percentage CHWs rated as a 'good performer' by their community (indicating satisfaction with the performance of the CHW).
    - Numerator: Number of CHWs rated as 'good performer' by their community
    - Denominator: Number of CHWs supported by the project

9. The indicator assumes that (a) the unit of analysis is the community with the possibility that the CHW may cover multiple communities or that multiple CHWs may operate in a community and (b) the performance measurement includes both an objective component and some aspect of community involvement (in assessing the quality of the services, in discussing the results, or another criterion indicating that there is an element of accountability).

[75] An ongoing study has shown that of 1,177 expected VDCs, 1,080 (or 92 percent) were active.
[76] The total number of FMCs is not known. However, studies under way indicate that more than 75 percent of existing FMCs meet two or three times a month.

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SIERRA LEONE
SELECTED CITIES AND TOWNS
DISTRICT CAPITALS
NATIONAL CAPITAL
RIVERS
MAIN ROADS
RAILROADS
DISTRICT BOUNDARIES
INTERNATIONAL BOUNDARIES
GUINEA
LIBERIA
ATLANTIC OCEAN
FREETOWN
WESTERN AREA F.R.
PORT LOKO
KAMBIA
BOMBALI
KOINADUGU
TONKOLILI
KONO
KAILAHUN
KENEMA
BO
MOYAMBA
BONTHE
PUJEHUN
Falaba
Yana
Kabala
Bendugu
Kamakwie
Fadugu
Kamaron
Madina Junction
Kambia
Pendembu
Batkanu
Bumbuna
Alikalia
Kurubonla
Mange
Gbinti
Makeni
Binkolo
Kayima
Port Loko
Lunsar
Magburaka
Matotoka
Teleya
Yengema
Sefadu
Lungi
Pepel
Masingbi
Njaiama-Sewafe
Masiaka
Yonibana
Yele
Gandorhun
Koindu
Songo
Waterloo
Mongeri
Kailahun
Buedu
Rotifunk
Moyamba
Dambara
Panguma
Banana Islands
Yawri Bay
Mano
Lago
Pendembu
Shenge
Sembehun
Bo
Daru
Blama
Kenema
Kribundu
Joru
Sherbro
Momaligi
Sumbuya
Matru
Turtle Islands
Sherbro Island
Bonthe
Potoru
Kittam
Pujehun
Zimmi
Lake Mabesi
Lake Mape
Fairo
Sulima
To Ouré-Kaba
To Kindia
To Faranah
To Forecariah
To Monrovia
To Kolahun
Wara Wara Mts.
Loma Mts.
Gori Hills
Bintimani (1948 m)
Great Scarcies
Little Scarcies
Rokel
Pampana
Seli
Bagbe
Moa
Jong
Sewa
Mano
13°W
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8°N
7°N
0 20 40 60 Kilometers
0 20 40 50 Miles
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