Document of
The World Bank

Report No: ICR00001396

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(IDA-H0210 and IDA-H2890)

ON A

GRANT

IN THE AMOUNT OF SDR15.1 MILLION
(US$ 20.0 MILLION EQUIVALENT)

AND

ADDITIONAL FINANCING GRANT
IN THE AMOUNT OF SDR 5.3 MILLION
(US$8.0 MILLION EQUIVALENT)

TO THE

REPUBLIC OF SIERRA LEONE

FOR A

HEALTH SECTOR RECONSTRUCTION AND DEVELOPMENT PROJECT

May 28, 2010

Human Development Sector
Health, Nutrition and Population (AFTHE)
Country Department AFCW1
Africa Region

CURRENCY EQUIVALENTS

Exchange Rate Effective March 2, 2010

Leones (Le)
Le 3,790 = US$1.00
Le 1.00 = US$ 0.000264

FISCAL YEAR
January 1 -- December 31

ABBREVIATIONS AND ACRONYMS

AfDB	African Development Bank
APL	Adaptable Program Lending
CAS	Country Assistance Strategy
CDC	Center for Disease Control and Prevention
CMR	Child Mortality Rate
CPR	Country Procurement Review
CPAR	Country Procurement Assessment Report
CTB	Central Tender Board
DGA	Development Grant Agreement
DHS	Demographic and Health Survey
DOTS	Direct Observed Treatment Short-course (TB)
DPI	Directorate of Planning and Information
EIA	Environmental Impact Assessment
EMP	Environmental Management Plan
EU	European Union
FMR	Financial Management Report
GDP	Gross Domestic Product
GF	Global Fund
GIMPA	Ghana Institute of Management and Public Administration
GOSL	Government of Sierra Leone
GPN	General Procurement Notice
HNP	Health, Nutrition and Population
HRD	Human Resources Development
HSRDP	Health Sector Reconstruction and Development Project
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IEC	Information, Education and Communication
IFC	International Finance Corporation
IHSIP	Integrated Health Sector Investment Project
KPI	Key Performance Indicator
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MICS-2	Multiple Indicator Cluster Survey-2
	Maternal Mortality Ratio
MOHS	Ministry of Health and Sanitation
NGO	Non-Government Organization
NHAP	National Health Action Plan

PCD	Project Concept Document
PCU	Project Coordination Unit
PDO	Project Development Objective
PER	Public Expenditure Review
PHC	Primary Health Care
PHRD	Policy and Human Resources Development
PHU	Primary Health Units
PIU	Project Implementation Unit
PMR	Project Monitoring Report
RBM	Roll Back Malaria
SAPA	Social Action and Poverty Alleviation
SBCQ	Selection Based on Consultants Qualification
SIL	Specific Investment Loan
TSS	Transitional Support Strategy
TB	Tuberculosis
TTL	Task Team Leader
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities
WA	Withdrawal Application
WBI	World Bank Institute
WHO	World Health Organization

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SIERRA LEONE
HEALTH SECTOR RECONSTRUCTION AND DEVELOPMENT PROJECT

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A. Basic Information			
Country:	Sierra Leone	Project Name:	Health Sector Reconstruction and Development Project
Project ID:	P074128	Grant Numbers:	IDA-H0210; IDA-H2890
ICR Date:	March 2, 2010	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	GOVERNMENT OF SIERRA LEONE
Original Total Commitment:	SDR 15.1M	Disbursed Amount:	SDR 18.8M
Revised Amount:	SDR 20.4M		
Environmental Category: B			
Implementing Agencies: Ministry of Health and Sanitation			
Cofinanciers and Other External Partners: None.			

B. Key Dates				
Process	**Date**	**Process**	**Original Date**	**Revised / Actual Dates**
Concept Review:	10/03/2001	Effectiveness:	05/28/2003	05/28/2003
Appraisal:	09/30/2002	Restructuring(s):		05/22/2007
Approval:	02/25/2003	Mid-term Review:	02/20/2006	02/06/2006
		Closing:	02/28/2008	12/31/2009

C. Ratings Summary			
C.1 Performance Rating by ICR			
Outcomes:		Moderately Satisfactory	
Risk to Development Outcome:		Moderate	
Bank Performance:		Satisfactory	
Borrower Performance:		Moderately Satisfactory	
C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)			
Bank	**Ratings**	**Borrower**	**Ratings**
Quality at Entry:	Satisfactory	Government:	Moderately Satisfactory
Quality of Supervision:	Moderately Satisfactory	Implementing Agency/Agencies:	Moderately Satisfactory
Overall Bank Performance:	Satisfactory	**Overall Borrower Performance:**	Moderately Satisfactory

C.3 Quality at Entry and Implementation Performance Indicators			
Implementation Performance	**Indicators**	**QAG Assessments (if any)**	**Rating**
Potential Problem Project at any time (Yes/No):	Yes	Quality at Entry (QEA):	None
Problem Project at any time (Yes/No):	Yes	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	Satisfactory		

D. Sector and Theme Codes	
Sector Code (as % of total Bank financing)	**Percent**
Central government administration	20
Health	70
Solid waste management	2
Sub-national government administration	8

Theme Code (as % of total Bank financing)	
Conflict prevention and post-conflict reconstruction	24
Health system performance	25
Malaria	25
Other financial and private sector development	13
Participation and civic engagement	13

E. Bank Staff		
Positions	**At ICR**	**At Approval**
Vice President:	Obiageli K. Ezekwesili	Callisto Madavo
Country Director:	Ishac Diwan	Mats Karlsson
Sector Manager:	Eva Jarawan	Alexandre Abrantes
Project Team Leader:	Evelyn Awittor	Astrid Helgeland-Lawson
ICR Team Leader:	Jean J. de St. Antoine	
ICR Primary Author:	Willy De Geyndt	

F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document)

The Health Sector Reconstruction and Development Project (HSRDP) is a SIL with some features of a sector-wide program.

The project's overall development objective was to help restore the most essential functions of the health sector delivery system. The project would also help achieve the more specific objectives of: (i) increasing access to affordable essential health services by improving primary and first referral health facilities in four districts of the country; (ii) improving the performance of key technical programs responsible for coping with the country's major public health problems; (iii) strengthening health sector management capacity to improve efficiency and further decentralize decision-making to the districts; and (iv) supporting development of the private NGO health sector and involvement of the civil society in decision-making.

Revised Project Development Objectives (as approved by original approving authority)

The Board approved an additional financing grant of US$8 million equivalent on May 22, 2007 that did not change the original project development objective, the general project design or the implementation modalities.

A. Original Grant				
Indicator	**Baseline Value**	**Original Target Values (from approval documents)**	**Formally Revised Target Values**	**Actual Value Achieved at Completion or Target Years**
Indicator 1	At least 50 health posts in the four priority districts are fully equipped as specified in the Project Implementation Plan.			
Value (quantitative or qualitative)	0	50	-	50
Date achieved	2003			December 18, 2009 (Equipment Distribution Report)
Comments	Target achieved.			
Indicator 2	At least 4 district hospitals in the priority districts have been rehabilitated and fully equipped with as specified in the Project Implementation Plan.			
Value (quantitative or qualitative)	0	4		3
Date achieved	2003			December 31, 2009
Comments	The fourth hospital, Kono Government Hospital is 85% complete			
Indicator 3	The number of insecticide-treated bed nets purchased under the Project and distributed to the population exceeds 160,000.			
Value (quantitative or qualitative)	0	750,000	160,000	160,000[1]
Date achieved	May 28, 2003			December 31, 2009
Comments	Target achieved.			
Indicator 4	The proportion of new TB smear-positive cases successfully treated under DOTS in the four priority districts is at least 85%.			
Value (quantitative or qualitative)	76.5%	85%	-	86.1%
Date achieved	May 28, 2006			December 31, 2009
Comments	Target achieved			
Indicator 5	At least 15 laboratories are capable of performing malaria microscopy.			
Value (quantitative or qualitative)	2	15	24	26
Date achieved	May 28, 2003			2008 Health Facility Survey Report
Comments	Target exceeded.			

[1] The data is from the Procurement Unit of the MOH and confirmed by the National Malaria Control Program. The original target value was 750,000, but was reduced to 160,000 at MTR when the GF came on board.

A. Original Grant				
Indicator	**Baseline Value**	**Original Target Values (from approval documents)**	**Formally Revised Target Values**	**Actual Value Achieved at Completion or Target Years**
Indicator 6	The health centers rehabilitated and equipped in the 4 priority districts have at least 0.5 contacts per inhabitant per year.			
Value (quantitative or qualitative)				
Date achieved				
Comments	This indicator was dropped at restructuring to be replaced by "the percentage of population within one mile radius from the nearest PHU in the four priority districts", considered a better measure of access to health services.			
Indicator 7	At least 60% of deliveries in the 4 priority districts will be assisted by a qualified provider.			
Value (quantitative or qualitative)				
Date achieved				
Comments	This indicator was dropped at restructuring because there were no corresponding project activities and institutional deliveries would be addressed under the forthcoming Reproductive and Child Health Project.			
Indicator 8	The bed occupancy rate in the hospital rehabilitated and equipped is at least 85%.			
Value (quantitative or qualitative)				
Date achieved				
Comments	This indicator was dropped at restructuring because the "percentage of children aged 12-23 months completely immunized" was considered a better measure of utilization.			
Indicator 9	The proportion of new TB smear-positive cases detected in the four priority districts is at least 70%.			
Value (quantitative or qualitative)	0%	70%	-	47%
Date achieved	May 28, 2003			December 31, 2009
Comments	Target not achieved.			
Indicator 10	The percentage of children under five years of age in the 4 priority districts who sleep regularly under insecticide-treated bed nets is at least 40%.			
Value (quantitative or qualitative)	1.5%	40%	-	66.4%

A. Original Grant				
Indicator	**Baseline Value**	**Original Target Values (from approval documents)**	**Formally Revised Target Values**	**Actual Value Achieved at Completion or Target Years**
Date achieved	May 28, 2003			December 31, 2009
Comments	Target largely exceeded.			
B. Additional Financing				
Indicator 11	The percentage of pregnant women in the 4 priority districts who sleep regularly under insecticide-treated bed nets is at least 40%.			
Value (quantitative or qualitative)	1.5%	40%	-	66.6%
Date achieved	May 22, 2007			December 31, 2009
Comments	Target exceeded.			
Indicator 12	Percentage of population within 5km radius from the nearest PHU, in the 4 priority districts increase from 41% in 2005 to at least 60% in 2007.			
Value (quantitative or qualitative)	41%	60%	-	67.3%
Date achieved				December 31, 2009
Comments	Target exceeded			
Indicator 13	Therapeutic coverage of Ivermectin[2], nation-wide increase from 0% in 2005 to 70% in 2007.			
Value (quantitative or qualitative)	0%	70%	-	75.3%
Date achieved	May 22, 2007			2008 Oncho Coverage Survey Report 15/01/2008
Comments	Target exceeded			
Indicator 14	Increase in geographic coverage of community-directed Ivermectin distribution from 0% in 2005 to 70% in 20007.			
Value (quantitative or qualitative)	0%	70%	-	100%
Date achieved	May 22, 2007			2008 Oncho Coverage Survey Report

[2] Anti-parasitic medication used against worms.

A. Original Grant				
Indicator	**Baseline Value**	**Original Target Values (from approval documents)**	**Formally Revised Target Values**	**Actual Value Achieved at Completion or Target Years**
				15/01/2008
Comments	Target exceeded			
Indicator 15	Percentage of children aged 12-23 months completely immunized is at least 75%.			
Value (quantitative or qualitative)	45%	75%	-	79.7%
Date achieved	May 28, 2003			2008 EPI Program Report December 31, 2009
Comments	Target exceeded.			
Indicator 16	At least 50% of PHUs in the 4 priority districts have either an incinerator or a burning pit.			
Value (quantitative or qualitative)	0%	50%	-	73.4%
Date achieved	May 28, 2003			2008 Health Facility Survey Report
Comments	Target largely exceeded.			
B. Additional Financing				
Indicator	**Baseline Value**	**Original Target Values (from approval documents)**	**Formally Revised Target Values**	**Actual Value Achieved at Completion or Target Years**
Indicator 17	The number of health workers trained on surveillance of Avian Influenza increased from 0 to 250.			
	0	0	250	430

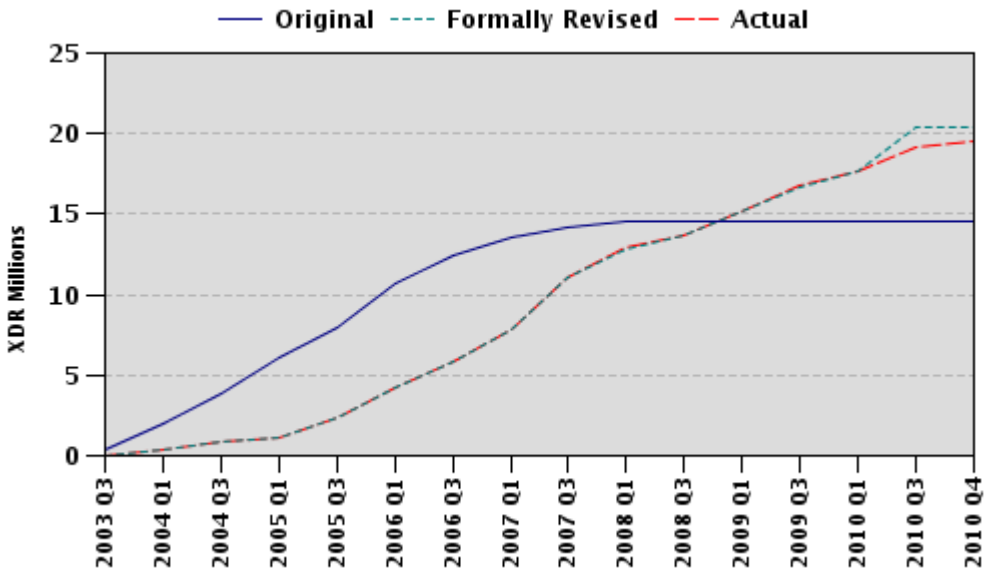
G. Ratings of Project Performance in ISRs

No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	03/26/2003	Satisfactory	Satisfactory	0.00
2	04/29/2003	Satisfactory	Satisfactory	0.00
3	11/13/2003	Satisfactory	Satisfactory	0.61
4	01/16/2004	Satisfactory	Satisfactory	0.96
5	05/11/2004	Satisfactory	Satisfactory	1.43
6	11/11/2004	Satisfactory	Satisfactory	2.03
7	12/30/2004	Satisfactory	Satisfactory	2.39
8	05/24/2005	Satisfactory	Satisfactory	3.89
9	12/14/2005	Satisfactory	Satisfactory	7.39
10	05/08/2006	Moderately Satisfactory	Satisfactory	9.24
11	11/13/2006	Moderately Satisfactory	Moderately Satisfactory	12.29
12	01/26/2007	Moderately Satisfactory	Moderately Satisfactory	14.66
13	06/12/2007	Satisfactory	Satisfactory	16.94
14	12/21/2007	Satisfactory	Satisfactory	19.17
15	02/28/2008	Satisfactory	Satisfactory	20.15
16	06/26/2008	Moderately Satisfactory	Moderately Unsatisfactory	21.56
17	12/30/2008	Moderately Satisfactory	Moderately Unsatisfactory	23.60
18	05/20/2009	Satisfactory	Moderately Satisfactory	25.06
19	11/10/2009	Satisfactory	Moderately Satisfactory	26.63
20	12/30/2009	Satisfactory	Moderately Satisfactory	27.49

H. Restructuring

Restructuring Date	Board Approved PDO Change	ISR Ratings at Restructuring		Amount Disbursed at Restructuring in USD millions
		DO	IP	
05/22/2007	None.	S	S	16.94

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1.1 Context at Appraisal

1. Sierra Leone endured a devastating civil war from 1992 to 2001. Most infrastructure and many formal institutions were destroyed or disabled. Some of the traditional institutions have been resurrected in the post-conflict era. Sierra Leone ranks near the bottom of the Human Development Index. In particular its social and human development indicators are deplorable. Life expectancy at birth is estimated to be only 43 years and infant and under-five mortality rates are respectively 170 and 286 per 1,000 live births. The maternal mortality ration is 1,800 per 100,000 live births. The disease burden is dominated by malnutrition, malaria, tuberculosis, leprosy, acute respiratory diseases, diarrheal diseases, Lassa fever, onchocerciasis, cholera and other water-borne diseases. The HIV prevalence rate was estimated by CDC to be about 4.9% in 2002. Insufficient use of contraceptives keeps fertility rates high. In many respects, the country is trying to catch up to its development level of three decades ago. Over half a million people fled the country during the war including up to 40% of its professionals and skilled workers. In February 2002, peace was declared after a ten year period of instability and brutal civil war. Since then, the collaboration between the government and the international community has stabilized the security situation and put an end to widespread violence and fear. Sierra Leone has now entered a more stable recovery state.

2. The Transitional Support Strategy (TSS) of 2002-2003 proposed the Health Sector Reconstruction and Development Project (HSRDP) as one of the lending activities. The project is fully consistent with the TSS and would rehabilitate health facilities with priority given to war-torn and underserved areas. Re-establishing the provision of basic health services and solving major public health problems are crucial steps to consolidating peace.

3. Grant financing was justified by the urgent need to restore a functioning health sector, its strong development impact and as a means to draw greater and broader support for the sector. At the time, the Bank was the only donor present with an office open in Sierra Leone. The project was not a sector-wide approach because the government, which had limited capacity at the time, preferred fully-designed but complementary projects from donors. Support was subsequently provided by DFID, UNDP and the EU who each supported a number of districts, in addition to the four supported by the Bank. The lending instrument is a SIL. Annual reviews were conducted jointly by all donors. DFID, the World Bank, the UNDP and the EU dominate the aid community. The economy has improved a good deal since the end of the war, but the country remains deeply dependent on aid flows which make up 70% of all public expenditures[3].

[3] "Parallel Implementation Systems, Capacity And Performance In Sierra Leone" Draft #1 (June 26, 2009) by Peter Morgan, Capacity Development consultant.

1.2 Original Project Development Objectives (PDO) and Key Indicators

4. The project's overall development objective was to help restore the most essential functions of the health sector delivery system. The project would also help achieve the more specific objectives of: (a) increasing access to affordable essential health services by improving primary and first referral health facilities in four districts of the country; (b) improving the performance of key technical programs responsible for coping with the country's major public health problems; (c) strengthening health sector management capacity to improve efficiency and further decentralize decision-making to the districts; and (d) supporting development of the private NGO health sector and involvement of the civil society in decision-making.

Key Indicators.

5. The Development Grant Agreement (DGA) dated February 29, 2003 included the following ten performance indicators in Schedule 6:

(a) At least 50 health posts in the Priority Districts are fully equipped as specified in the Project Implementation Plan.
(b) At least 4 district hospitals in the Priority Districts have been rehabilitated and fully equipped as specified in the Project Implementation Plan.
(c) The number of insecticide-treated bed nets purchased under the project and distributed to the population exceeds 750,000.
(d) At least 15 laboratories are capable of performing malaria microscopy in the territory of the Recipient.
(e) The percentage of children under five years of age in the Priority Districts who sleep regularly under insecticide-treated bed nets, is at least 40%.
(f) The percentage of TB smear-positive cases successfully treated under the directly observed treatment strategy in the Priority Districts is at least 85%.
(g) The proportion of new TB smear-positive cases detected in the four priority districts is at least 70%.
(h) The health centers rehabilitated and equipped in the four Priority Districts have at least 0.5 contacts per inhabitant per year.
(i) At least 60% of deliveries in the four Priority Districts will be assisted by a qualified provider
(j) The bed occupancy rates in the hospitals rehabilitated and equipped is at least 85%.

1.3 Revised PDO (as approved by original approving authority) and Key Indicators, and reasons/justification

6. The Board approved an additional financing grant of US$8 million equivalent on May 22, 2007 that did not change the original project development objective, the general project design or the implementation modalities. The Government had requested additional financing for three activities that are consistent with the original PDOs, with the priorities set out in the CAS of May 2005 (to improve the health status of the people of Sierra Leone) and with the PRSP. These activities were: (a) scale up onchocerciasis control and prevention, a debilitating and often blinding disease endemic in tropical areas of Africa, which was expected to be financed from other sources that did not materialize (US$2.7 million equivalent); (b) strengthen Avian Influenza awareness and preparedness as there were two known outbreaks of H5N1 (avian flu) in 2006 (US$0.40 million equivalent); and (c) improve the operational conditions of health facilities by completing civil works that face cost overruns due to increased unit costs of building materials, and adding to the original list hospitals and community health centers that lacked adequate infrastructure to deliver project activities (US$4.75 million equivalent). Additional financing included an unallocated category of US$0.15 million equivalent. Project restructuring also financed a smaller amount of malaria control activities as the Global Fund (GF) was now financing malaria commodities including bed nets.

7. The Financing Agreement amending the earlier DGA dated July 11, 2007 included the following 15 key indicators replacing two earlier indicators, scaling back one and adding five new ones[4]:

Indicator	Changes from 2003 DGA - Schedule 6
1. At least 50 health posts in the Priority Districts are fully equipped.	No change
2. At least 4 district hospitals in the Priority Districts have been rehabilitated and fully equipped.	No change
3. Percentage of population within one mile radius from the nearest primary health unit in the Priority Districts increase from 41% in 2004 to at least 60% in 2007.	Replaces "assisted deliveries" indicator which will be addressed under the forthcoming Child Survival and Maternal Health Program
4. Twelve (12) primary health facilities fully rehabilitated and equipped in the Priority Districts.	New indicator
5. Percentage of children aged 12-23 months	Replaces an invalid indicator on

[4] The final ISR does not include the last two indicators on this list but adds immunization with DPT3/Penta for children under one, and Number of patients treated for TB.

completely immunized is at least 75%.	"bed occupancy rates of 85%"
6. The number of insecticide-treated bed nets purchased under the project and distributed to the population exceeds 160,000.	Scaled back from 750,000 - Global Fund financing now available for malaria
7. At least 15 laboratories are capable of performing malaria microscopy in the territory of the Recipient.	No change
8. The percentage of pregnant women in the Priority Districts who sleep regularly under insecticide-treated bed nets is at least 40%.	No change
9. The percentage of pregnant women in the Priority Districts who sleep regularly under insecticide-treated bed nets is at least 40%.	Added
10. The percentage of TB smear-positive cases successfully treated under the directly observed treatment strategy in the Priority Districts is at least 85%.	No change
11. The proportion of new TB smear-positive cases detected in the four priority districts is at least 50%.	No change
12. At least 50% of primary health units in the four priority districts have either an incinerator or a burning pit.	Measures new activity
13. Therapeutic coverage of Ivermectin nationwide increase from 0% in 2005 to at least 60%.	Measures new activity
14. Increase in geographic coverage of community-directed Ivermectin distribution from 0% in 2005 to 70%.	Measures new activity
15. The number of health workers trained on surveillance of Avian Influenza increased from 0 in 2006 to 250.	Measures new activity

1.4 Main Beneficiaries,

8. Beneficiaries would be the total population for some activities and a subset of the population for others. Four mid-size rural districts were identified for restoring essential health services and benefitted the mostly rural population of these districts. The four districts (out of a total 13) were chosen by the government using the following criteria: (i) their importance for the demobilization, resettlement and peace processes; (ii) the magnitude of the public health problems; and (iii) the poor quality of the health infrastructure that urgently needed rehabilitation.

9. In principle, the entire population benefitted from the three priority public health programs (malaria, tuberculosis and sanitation), but the poor derived more benefits as these conditions mainly affect the indigent and underserved population groups. The actions to augment the capacity of the public and private sectors through decentralized

decision making and improving the performance of district health teams made the health system more responsive to the needs of the population.

1.5 Original Components

10. **Component 1**(US$15.2 million)**: Restoring essential health services** through (i) restoring health service delivery in four priority districts (Bombali, Koinadugu, Kono and Moyamba) out of a total 13 districts in the country, and (ii) supporting three priority technical programs to improve their performance and control infectious diseases of high public importance in Sierra Leone (malaria, tuberculosis, and sanitation); and

11. **Component 2** (US$5.98 million)**: Strengthening public and private sector capacity** through (i) fostering decentralization and improving the performance of District Health Management Teams; (ii) strengthening the key MOHS support programs in the area of human resources development, planning, financial management, monitoring and statistics, procurement and donor/NGO coordination; and (iii) promoting development of the private sector and participation of civil society in the health sector.

1.6 Revised Components

12. The two original components were not revised for the approved additional financing.

1.7 Other significant changes

13. **Additional Financing**. A request for additional grant in the amount of US$8 million equivalent for restructuring the project was approved by the Board on May 22, 2007. No changes to the project development objective, general design, and implementation modalities were sought. The additional funds were requested to help finance the costs associated with (a) completing original civil works activities that face cost overruns, and (b) implementing additional activities related to the control and prevention of onchocerciasis and avian influenza. The restructuring would support (a) modification of key performance indicators to strengthen the project focus on critical health outcomes, and (b) reducing IDA financing for the malaria program in response to increased funding for these activities now available from other development partners.

14. The original ten performance indicators were modified and were increased to 15 in order to measure the activities approved under the additional financing as detailed in Section 1.3 above. The original IDA funding for malaria was redeployed to other high priority uses in the health sector as another donor (GF) was now financing the Government's malaria program. The closing date was extended by 18 months from February 28, 2008 to August 31, 2009. An additional four month extension was granted to enable works to be completed on the four district hospitals, three Primary Health Units and the dumpsites. A Financing Agreement dated July 11, 2007 amended and restated the DGA.

15. The additional financing was consistent with the Bank's conditions for Additional Financing as stated in BP 13.20 (June 2005). It was also consistent with the strategic priorities set out in the current Country Assistance Strategy (CAS, Report No. 31793, May 5, 2005) and the PRSP. It supported the long-term country development outcome set out in the third pillar of the CAS "to improve the health status of the people of Sierra Leone," and directly feed into the specific CAS outcome "to restore and develop the health sector in four districts."

2. Key Factors Affecting Implementation and Outcomes

2.1 Project Preparation, Design and Quality at Entry

16. **Project Preparation**. Project preparation was initiated with the issue of a PCD on July 12, 2001 that received comments from ten peer reviewers. A PHRD grant (TF026871 and TF026794) from the Japanese Government for US$400,000 (of which US$210,693 was spent) was received and used for consulting services to conduct studies such as: Social Assessment; Project Implementation Plan/Operational Manual; Environmental Assessment; Public Expenditure Review for the health sector; Health Facility Inventory; Health Sector Priorities Issues and Strategic Approaches; Human Resources Assessment; Update of the Health Sector Policy; and National and District Health Plans and a Three-Year-Rolling Plan. A request for a Project Preparation Facility in the amount of US$593,600 was made by the GOSL on March 5, 2002. The draft PAD was discussed at a meeting on September 5, 2002 with comments received from one peer reviewer. The original grant in the amount of SDR 15.1 million (US$20.0 million equivalent) was approved by the Board on February 25, 2003. The time elapsed between project initiation and Board approval was 20 months. The Grant Agreement was signed on February 28, 2003 with an expected closing date of February 28, 2008. The Project's technical launch took place on April 1-2, 2003 and the grant became effective on May 28, 2003. The total project cost was US$21 million, of which the Government was expected to finance US$1 million. However, on January 22, 2007, IDA agreed to allow 100 percent financing of all eligible expenditures according to the Country Financing Parameters. Not contributing the agreed on counterpart funds had been delaying some project activities, especially the civil works, with contractors not being paid on time.

17. Comments from the ten reviewers on the PCD were generally supportive of the relevance, approach and design of the project with suggestions for minor rewording of PDOs, regrouping the components and subcomponents. On the key performance indicators they cautioned that it was doubtful that the project would have a measurable impact on IMR, CMR and MMR. Nonetheless these indicators remained in the PAD but were subsequently not included in Schedule 6 of the DGA or in the ISRs. Several peer reviewers pointed out "*the long-term special history the Bank has with the MOH*" and the "*surprisingly satisfactory past performance of the Ministry of Health under extraordinary constraints*".

18. The DO and the IP of three earlier Bank-financed projects (HNP, Social protection, HIV/AIDS) had been rated Satisfactory. A Quality of Supervision of Risky

Projects was carried out by a QAG panel for the previous Health Sector project (ID: P002422) and the panel concluded that the quality of supervision during FY 00 and FY 01 was satisfactory overall. The panel cited that the team had demonstrated strong commitment by maintaining a dialogue with the Ministry of Health under very difficult circumstances and by addressing the health problems as the country emerged in a post-conflict situation. In general, the Bank's contribution to the health sector in Sierra Leone was much praised by the Borrower and the development partners.

19. The Government proceeded meanwhile to meet the conditions for negotiations including improving the accounting and financial system and strengthening the procurement unit of MOHS, and issuing a procurement plan, an accounting manual and an operational manual.

20. Preparation for the additional financing moved swiftly and smoothly in 2007 with Board approval in May and signing of the Financing Agreement in July.

Project Design.

21. The project concept of this Sector Investment Loan was well justified and, given the satisfactory past performance of the MOHS under extraordinary constraints, was judged to have a reasonable chance to be properly implemented. The overall objective was stated simply as helping to restore the most essential functions of the health delivery system. The two components addressed specific health sector issues, i.e. improving essential health services in four districts, reducing the disease burden of three public health priority programs (malaria, tuberculosis and sanitation), and strengthening five MOHS key departments. Some features of the earlier satisfactory sector-wide health program were retained, namely, annual review of the relevance of activity-specific allocations, an operational planning process, coordination of donor support, and promoting the development and use of the private sector and civil society in general. The project also retained the earlier implementation approach of not creating a separate project implementation unit (PIU) but to implement the project through the MOHS organizational structure. This latter feature was retained based on the MOHS having succeeded to implement the previous credit satisfactorily in spite of the difficult conditions that prevailed in the country from 1995 to 2001.

22. The MOHS was the overall executing agency of the grant contracting out some activities to NGOs and the provision of selected technical programs to private not-for-profit providers under the purview of the Planning Department and the guidance of the Director General of Medical Services. The Bank preparation team was well staffed with a skills mix that included specialists in public health, infectious diseases, procurement, financial management, and implementation.

23. Critical risks are judged to be conservative. Six of the seven risks listed in the PAD were rated as substantial and one as moderate. Risk mitigation measures were largely hopeful and optimistic. Peace was gradually returning to Sierra Leone but there were still high risks in restoring health care delivery in the selected areas in an unstable

political situation, recruiting and deploying staff to these areas and ensuring their availability when the infrastructure was completed, coordinating donor support and effectively applying a decentralization policy. The project was mainly dependent on donor-funding and aspects of the project requiring continuous funding (civil works/maintenance, training medical personnel, drug supplies) raise issues of sustainability over the long run.

24. Financial implementation arrangements were sensible. A warning note was sounded about the risks and practicalities of the flow of funds to decentralized units given the poor or non-existent banking system in certain areas and the ability to safeguard and control decentralized funds.

25. The Project Paper for the Additional Financing noted some of the risks that were classified as substantial at the time of Project approval that were being addressed, namely, the risk of weak capacity of the MOHS to implement sector reform was downgraded from substantial to moderate and the risk associated with insufficient political determination to effect the decentralization policy had become negligible. The Government was implementing a decentralization policy with primary health decentralized to the local councils. The risk of poor coordination of donor programs was downgraded from substantial to moderate. The same paper stated that while Sierra Leone was rated as a high risk country due to poor governance, the ministry has implemented the on-going project effectively and efficiently, with no significant problems related to financial management or procurement.

Quality at Entry.

26. The project was well prepared and ready for implementation. A PHRD Grant of US$ 400,000 from the Japanese Government was used to conduct studies including: (i) a social assessment; (ii) Operational Manual; (iii) Project Implementation Plan; (iv) Environmental Assessment; (v) Public Expenditures Review for the Health Sector; (vi) Health Facility Inventory; (vii) Health Sector Priority Issues and Strategic Approaches; (viii) Human Resources Assessment; (ix) update of the Health Sector Policy; and (x) National and District Health Plans and a Three-Year-Rolling Plan. In addition, Project Preparation Facility funds were used by the government to develop and update financial accounting manual and improve FM systems required under the project.

27. There was already a PIU under the previous Health Sector Project with staff having experience in the implementation of Bank-financed projects. Most of them were contracted for the Health Sector reconstruction project.

28. The financial management and procurement assessment concluded that the MOH had the proper structure and systems to implement the project, all properly documented in an Operational Manual. The engineering design documents for the first year's activities were complete and ready for the start of project implementation. The procurement documents for the first year's activities were also complete and ready. The Project Implementation Plan was appraised and found to be realistic and of satisfactory quality.

There was only one main condition on counterpart funding and it was easily complied with.

29. The results framework included 15 indicators which would measure the contribution of the project to its objective. Baseline data were not available at appraisal, but were collected during the annual sector review and operational planning exercise for 2003. The indicators were largely well chosen, except for thee of them (indicators 6-8) which were dropped at restructuring.

2.2 Implementation

30. **Disbursement Overview**. Disbursements were slow at the outset with only 9% disbursed after 1 1/2 year of operations. Subsequent years saw accelerated rates of disbursements of 33%, 55% and 86% respectively by the end of 2005, 2006 and 2007. With the additional financing the disbursement rate dropped to 77% in 2008 but the overall disbursement rate by closing in December 2009 was US$27.7 million or 98%. The disbursement profile is presented in Section I of the Data Sheet.

Implementation Overview.

31. The Ministry of Health and Sanitation (MOHS) executed and implemented the project with some activities contracted out to NGOs. The institutional and organizational arrangements followed the precedent set by the previous health project that was rated satisfactory. A separate Project Implementation Unit (PIU) was not created and the activities to be implemented under the project were integrated in the existing structure of the MOHS. The Project director was the Director General of Medical Services (similar to a Permanent Secretary) and the Director of Planning was the Project Coordinator. All MOHS staff working on the project were paid out of grant funds setting up a sustainability issue as will be discussed further on. While it is correct that *de jure* there was no separate PIU it must be recognized that the "integrated PIU" was *de facto* a team that were not civil servants but were paid higher salaries.

32. Project implementation during the first year showed satisfactory progress with bidding documents including drawings and bills of quantities for the four district hospitals and the 12 health centers prepared, bids for procuring furniture and equipment advertised, planning and budgeting workshops conducted, staff trained in procurement at a WBI course in Nigeria, and discussions initiated with NGOs. Slowing down some activities were the shortage of health workers, especially in rural areas, and the delay in recruiting a supervising architect, a profession in short supply.

33. Progress during the second year was also rated satisfactory although important delays were encountered in the bidding process with bids being opened and evaluation reports sent to the Bank for review towards the end of the year. Nonetheless procurement was rated surprisingly satisfactory. Furniture and equipment were procured for community health centers, laboratory technicians were trained but the procurement of bed nets was delayed. The project continued to be hampered by a shortage of health workers

and specific skills such as an architect manager and a quantity surveyor firm. This delay caused a low disbursement rate of only 9.3% of grant funds against an unrealistic goal of 37.6% projected in the PAD. The Environmental Assessment was completed and found no significant environmental issues.

34. Significant progress was made during the third year. Construction of works for the rehabilitation of the selected four hospitals and 12 health centers had started, procurement of equipment for these facilities had been initiated, and drugs, furniture and the first batch of 7,000 bed nets had been procured and distributed. Problems with counterpart funding emerged and discussion of allowing 100% Bank financing had started. Disbursement delays were now compounded by delays in signing withdrawal applications. The latter had to be signed by both the Minister of Health and the Minister of Finance, resulting in delays from six months to one year. Delays in disbursement caused a slowdown in civil works as contractors were not paid on time.

35. The Mid-Term Review took place on schedule in February 2006, during the third year of project implementation. The MTR recommended to: (i) merge some subcomponents; (ii) scale down the malaria activities as the Global Fund had recently committed additional funds to support the government's malaria program; (iii) scale up the civil works program to take into consideration some changes in scope as well as cost over-runs; (iv) add activities to support the control of onchocerciasis and avian flu which were important priorities for the government; and (v) revise key performance indicators (KPIs) to reflect a better linkage with project activities and make them more specific, measurable, and outcome-based. The proposed changes made sense and largely led to the Additional Financing of US$8.0 million.

36. The fourth year saw a downgrading of DO and IP from S to MS for the first time. The counterpart funding issue had not yet been solved as the task team had discussed with GOSL 100% financing in exchange for an increase in GOSL financing of the health sector. The GOSL could not agree to this and the team agreed to request Bank Management to allow 100% financing without the corresponding budget increase. At the same time the team started preparing a proposal for additional financing. A tracking system for processing withdrawal applications was put in place to clear the backlog. Civil works did not advance as quickly as anticipated, and only five of the 12 health centers were completed and the rehabilitation of the four district hospitals were at various stages of completion. However progress towards achieving a number of KPIs was improving especially in malaria and tuberculosis diagnosis and treatment.

37. The MS rating of DO and IP were reversed in the fifth year as a result of: IDA Management approving 100% financing and a positive improvement in all the KPIs with four of them already exceeding their target. The approved additional financing set the stage for speeding up the rehabilitation works on the hospitals as contractor payments improved. The temporary improvement in processing WAs saw a set back with elections in July/August 2007 and the appointment of new ministers.

38. Ratings were sharply downgraded in the sixth year: DO moving back to MS, IP going from S to MU, project management rated unsatisfactory, and MU for procurement, safeguard compliance (delays in dumpsite construction) and inexplicably for counterpart funding. The main reasons for lowering the IP rating were the implementation delays of civil works that account for 30% of project cost, the sharp increase in the prices of materials putting in doubt the successful financing of civil works, and the arrears owed to contractors due to the perennial problem of delayed processing of WAs. The procurement officer and the architect were dismissed and were not replaced. At the same time achieving the DO remained more positive with seven KPIs having met or exceeded their target.

39. Progress during the final year recuperated ending the project on a positive note. Overall disbursements and commitments were 98% by closing. A second closing time extension of four months allowed completing the civil works. Access to affordable essential health services increased and NGOs and civil society in general had become more active in decision making and participating in national planning, preparing health strategies and updating health policies. The procurement capacity of the MOHS remained unsatisfactory with delays in obtaining approvals and clearances and political interferences.

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

40. The PAD in "Annex 1: Project Design Summary" shows a list of 13 outcome/impact indicators and 23 output indicators under the heading of Key Performance Indicators. There is no M&E narrative in the PAD regarding design and implementation. Aide memoires and ISRs rarely mention M&E, but the outcome indicators were updated regularly during implementation support missions. The number of KPIs changed very much during project implementation. The DGA in Schedule 6 has ten performance indicators (Section 1.2 above). The February 2006 MTR recommended some changes to the key performance indicators by adding indicators to cover additional activities and sub-components, dropping some as they had become irrelevant and also changing some targets due to new developments. The request to effect these changes were included in the Additional Financing request (Section 1.3 above). The Project Paper on additional financing has a list of 15 KPIs in Annex A and the same list is also in the ISRs. The final aide memoire however updated the KPIs as of November 2009 and has only 12 indicators. The target values of three indicators differ between the final aide memoire and the final ISR. In general and despite the many changes in indicators, M&E was carried out satisfactorily with regular updating and use of data by the MOHS in planning.

41. A Demographic and Health Survey (DHS) completed in 2008 made possible updating three indicators relating to malaria ITNs and onchocerciasis. The reproductive and child survival project under preparation benefitted from the current project as activities aimed at strengthening routine data systems were on-going and training being planned for M&E officers at the decentralized levels. A health facility survey was planned to assess the quality of services provided in the country's health facilities. This

very first demographic and health survey (DHS) started data collection in March, 2008. The health facility survey and the DHS are not funded from project proceeds, but they provide useful additional information on the health status of the people of Sierra Leone.

2.4 Safeguard and Fiduciary Compliance

42. **Environment**. The project was categorized as "B" and a limited environmental analysis and a costed mitigation plan were to be prepared before project appraisal.

43. Environment and social safeguards implementation has been partial. Due diligence was exercised during construction of the hospitals at Makeni, Moyamba, Kabala and Kono. The sole household that was displaced as a result of the Makeni hospital construction was moved into a replacement house.

44. Institutional cooperation for waste management was weak all along in the work of the MOHS. The Environmental and Sanitation Department of MOHS that should have provided technical support in areas relating to environmental management and sanitation was conspicuously missing in the implementation of project activities. Reports from consultants preparing the EIAs and EMP for the dumpsites benefited only partially from inputs or comments from the staff of the Ministry and social impact assessments. The construction of landfill and dumpsites received a no objection from the World Bank for the construction of the Moyamba and Kabala dumpsites and advice was given for the Kono and Makeni sites to be changed after several visits and assessments noted their unsuitability for use as landfill and dumpsites. None have been constructed. MOHS submitted bidding documents for tendering for dumpsites construction after more than two years with support from the Bank to complete the site-specific environment impact assessment. A review of the bidding document found that technical descriptions were not provided and there was no clarity on what was required by the Ministry. The Bank team, on consultation with the procurement hub coordinator, advised the MOHS to use part of project funds allocated for the construction to hire consultants to prepare technical specifications for the dumpsites before the project closes. Because it ran out of time, the Ministry agreed to find funding from other sources for the construction of the dumpsites. The Bank team took the right approach of ensuring that design was appropriate. Even though this delayed their implementation, it will be beneficial to the country over many years.

Procurement, Disbursement, and Financial Management

45. Financial management was handled by the Project Finance Unit with a staff strength of five, comprising; Finance Director, the Project Accountant, a Finance Officer, and two secretarial staff. The project accountant and his team satisfactorily handled the accounting and reporting functions of the project. ISR ratings for financial management were uniformly satisfactory for the first four years of project implementation and then changed to moderately satisfactory for the remaining two years. The change appears to be due to the perennial problem of delayed processing of withdrawal applications and a major delay in paying up the outstanding counterpart fund contributions.

46. ISR ratings for procurement were also uniformly satisfactory for the first four years of project implementation and then changed, first to MS in 2007, then to MU in 2008 ending up in the final ISR with an unsatisfactory rating. A number of serious procurement issues emerged in the last two years. Substandard items (beds, generators, scales, and chairs) supplied to various hospitals, were discarded and were not replaced. The MOHS failed to comment on findings and recommendations made by the independent consultants in their technical audit reports submitted in June 2009. Ineligible items were procured and the MOHS was requested to refund to the project account the amount spent. As a result of agreements reached during the March 2009 mission, UNICEF was contracted to procure the remaining goods required under the project and supply of these items was completed by project closure. On the positive side, the offices and the stores of the Malaria Control Program Office and Store at New England Ville and the Environmental Health Division Office and Store at Clinetown were completed and handed over to MOHS.

47. One month before project closing, disbursements stood at 85.4% and 11.4% committed under signed contracts for a total of 96.8% disbursed and committed. The balance of non-committed funds was to be used to buy drugs for the health facilities through the UNICEF procurement system. This was not done, however, as the withdrawal applications were not signed on time.

2.5 Post-completion Operation/Next Phase

48. The HSRDP management was mainstreamed into the MOHS management system and was paid a salary out of grant funds that was higher than the government salaries. It provided the majority of professional staff that worked in the Ministry, with logistical support, transport facilities, internet services and communications for the senior management team. Mainstreaming also meant that project staff had to carry out functions of the Ministry and therefore sometimes were not available for project activities leading to delays in project implementation. This arrangement was presented by the client and accepted by the Bank as an "integrated PIU" versus a freestanding PIU. This mainstreaming helped the Ministry, but also made it possible for senior management and political leadership to interfere with the implementation of project activities at all levels contributing to delays in processing withdrawal applications at the MOHS and finalizing procurement decisions. Delays were also reported at the Ministry of Finance and Economic Development in processing withdrawal applications.

49. The MOHS prepared a draft exit and sustainability plan that would give the local councils responsibility for the operation and maintenance of the Primary Health Units and the secondary hospitals that have been rehabilitated or constructed under the project. Already funds have been allocated to the Local Councils for that purpose. Almost all members of the "integrated PIU" were absorbed by the GOSL and became government employees again, albeit at a lower salary.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation

50. The relevance of the overall development objective and the four subsidiary objectives is rated **Substantial** because: (i) Sierra Leone endured a devastating civil war from 1992 to 2001 and most infrastructure and many formal institutions were destroyed or disabled; and (ii) the objectives were consistent with the Bank's overall policies and country strategy.

51. The development objective aimed to help restore the most essential functions of the health sector delivery system. This objective would be achieved by: (a) increasing access to affordable essential health services by improving primary and first referral health facilities in four districts of the country; (b) improving the performance of key technical programs responsible for coping with the country's major public health problems; (c) strengthening health sector management capacity to improve efficiency and further decentralize decision-making to the districts; and (d) supporting development of the private NGO health sector and involvement of the civil society in decision-making.

52. Additional financing did not change the development objectives, but added three activities: (a) scaling up onchocerciasis control and prevention; (b) strengthening Avian Influenza awareness; and (c) improving the operational conditions of health facilities by completing civil works that were facing cost overruns due to increased unit costs of building materials.

53. The PDOs were and remained consistent with the Transitional Support Strategy (TSS) of 2002-2003 that included the Bank's business plan and proposed the Health Sector Reconstruction and Development Project (HSRDP) that would rehabilitate health facilities with priority to war-torn an underserved areas, re-establishing the provision of basic health services, and solving major public health problems to consolidate peace. The Additional Financing was also consistent with the strategic priorities set out in the Country Assistance Strategy (CAS, Report No. 31793, May 5,2005) and the PRSP. They support the long-term country development outcome set out in the third pillar of the CAS "to improve the health status of the people of Sierra Leone," and directly feed into the specific CAS outcome "to restore and develop the health sector in four districts."

54. The design was highly relevant. It was a simple one, taking into consideration the post-conflict situation and the limited capacity of the government. It was directly in line with the Bank country and sector strategies, as already mentioned earlier. The project components were consistent with the project's development objectives. Some changes were made after the MTR which helped adapt the project design to changing circumstances in Sierra Leone (notably for civil works), evolving needs from the government (onchocerciasis and avian flu), and availability of financing (Global Fund for malaria). Changes in a few indicators and targets allowed to better measure the project's impact.

3.2 Achievement of Project Development Objectives

55. The project's achievement of its overall development objective - helping restore the most essential functions of the health sector delivery system - is rated as **Substantial** based on the results of the four subsidiary objectives: increasing access to affordable essential health services (substantial); improving the performance of key technical programs (substantial); strengthening health sector management capacity to improve efficiency and further decentralize decision-making to the districts (modest); and supporting development of the private NGO health sector and involvement of the civil society in decision-making (modest). The rating is justified given that ten of the 15 indicators attained or surpassed their targets. Details are available below, in the Data Sheet and in Annex 2.

56. IDA was the only donor active in the four districts for rehabilitating the physical infrastructure objective and therefore results for that objective can be reasonably attributed to project activities. The 15 indicators listed and reported in the final ISR all refer to this objective. No quantitative results information is available for the second objective aiming at strengthening public and private sector capacity. As mentioned earlier, the number of indicators varies according to the document source: 10 in the DGA, 15 in the annex to the project paper for additional financing, 12 in the final aide memoire and 16 in the final ISR. The list below is the one from the Board approved additional financing grant and the results cited are from the final ISR dated 12/30/2009.

Objective 1: Restoring essential health services

Indicator	Target	Result
1. At least 50 health posts in the Priority Districts are fully equipped.	50	50
2. At least 4 district hospitals in the Priority Districts have been rehabilitated and fully equipped.	4	4
3. Percentage of population within one mile radius from the nearest primary health unit in the Priority Districts increase from 41% in 2004 to at least 60% in 2007.	60%	67.3%
4. Twelve (12) primary health facilities fully rehabilitated and equipped in the Priority Districts.	12	12
5. Percentage of children aged 12-23 months completely immunized is at least 75%.	75%	79.7%
6. The number of insecticide-treated bed nets purchased under the project and distributed to the population exceeds 160,000.	160,000	160,000
7. At least 15 laboratories are capable of performing malaria microscopy in the territory of the Recipient.	24	26
8. The percentage of children under five years of	40%	67.2%

age in the Priority Districts who sleep regularly under insecticide-treated bed nets, is at least 40%.		
9. The percentage of pregnant women in the Priority Districts who sleep regularly under insecticide-treated bed nets is at least 40%.	40%	63.2%
10. The percentage of TB smear-positive cases successfully treated under the directly observed treatment strategy in the Priority Districts is at least 85%.	85%	86.1%
11. The proportion of new TB smear-positive cases detected in the four priority districts is at least 50%.	50%	47%
12. At least 50% of primary health units in the four priority districts have either an incinerator or a burning pit.	50%	73.4%
13. Therapeutic coverage of Ivermectin nationwide increase from 0% in 2005 to at least 60%.	60%	75.3%
14. Increase in geographic coverage of community-directed Ivermectin distribution from 0% in 2005 to 70%.	70%	100%
15. The number of health workers trained on surveillance of Avian Influenza increased from 0 in 2006 to 250.	250	430

57. All of the 15 indicators, except two for tuberculosis, achieved or surpassed their target.

58. **Objective 2: Strengthening public and private sector capacity**. Documentation to fully assess this component does not provide quantitative data and qualitative information is quite limited in the narratives of the aide memoires and the ISRs. The private NGO health sector and civil society are reported to have become active in decision-making in the health sector. NGOs participated in the district and national planning and review processes during project implementation. They were also active in preparing the national health strategy and the update of the national health policy and their dissemination. This involvement is expected to continue for many years.

59. The project boosted the capacity of the MOHS through its support for a more efficient organizational structure, increased its ability to plan and budget, and trained key staff. A National Health Accounts system was set up in 2007 that laid the groundwork for future annual reporting on health expenditures. The Health Management Information System (HMIS) attracted the support of the health metrics network of WHO as well as support from CDC. Donor coordination improved with regular donor meeting and monthly NGO meetings. Less positive are the reports on the public sector that mentioned the perennial problem of delays in processing withdrawal applications at the MOHS and

the Ministry of Finance and to a lesser extent delays in finalizing procurement decisions by MOHS, and the changes in personnel at the senior level of MOHS.

3.3 Efficiency

60. Project efficiency is rated as **Modest** based on considerations of: (a) the allocation of funds to the two components with the bulk of the grant allocated to restoring essential health services; (b) the boosting of the capacity of the MOHS; (c) the delays in processing withdrawal applications and as a result delays in completing the civil works on time; and (d) cost overruns. The project invested in activities that have well documented cost effectiveness ratios such as improving basic health services, primary health care, first referral health facilities, human resources development, and support to programs addressing important infectious disease controls (malaria, tuberculosis, onchocerciasis, sanitation). The latter represent a major economic burden on the country by lowering the productivity of workers and increasing the cost of treatment.

61. An economic analysis was not conducted but instead a health sector Public Expenditures Review was carried out at the preparation phase. It was correctly recognized that until economic development takes off, the funding of the health sector would largely depend upon donor funding and that the present credit would not be sustainable until there is substantial macroeconomic development.

62. At the outset the country was required to contribute about US$1 million in counterpart funds representing about a 2% annual increment of MOHS current and capital expenditures funded from domestic sources. However, IDA agreed in January 2007 to allow for 100 percent financing of all eligible expenditures according to the Country Financing Parameters, without which delays in implementation would have been more significant.

3.4 Justification of Overall Outcome Rating

63. Rating: **Moderately satisfactory** based on the relevance of the overall development objective and the four subsidiary objectives rated as substantial, the appropriate design with major emphasis on restoring essential health services and controlling infectious diseases, the noted delays in implementation progress and cost overruns, the achievement of most performance indicators and the modest efficiency rating.

3.5 Overarching Themes, Other Outcomes and Impacts
(a) Poverty Impacts, Gender Aspects, and Social Development

64. The project's overall development objective of helping to restore essential functions of the health delivery system was applied to four districts. This responded to the goal of the Sierra Leone Poverty Reduction Strategy to redress inequities between Freetown and the rest of the nation as being central to maintaining peace. The four districts were mid-size rural districts affected by the war, and restoring the essential health services offered a comparative advantage to the poor. Grants were disbursed

directly to District Health Management Team (DHMT) accounts. This financing mechanism improved the pro-poor orientation of public spending. The first component - restoring essential health services - accounted for 71% of the original grant and for 68% of the combined original grant and additional financing. The same component financed nation-wide malaria, tuberculosis, and onchocerciasis programs that mainly affect the low income segment of the population as do the lack of sanitation programs. Both the district-specific and the nation-wide programs stressed the health of children and pregnant women as evidenced in the choice of key performance indicators. The second component - strengthening public and private sector capacity - made the health delivery system more responsive to the needs of the rural population by promoting the decentralization of decision-making.

(b) Institutional Change/Strengthening

65. The country emerged from a decade long civil war and institutions had to be rebuilt. Both PDOs contributed to rebuilding and strengthening the institutional infrastructure that enabled the country to provide essential health services to the whole population and to provide the managerial capacity to manage the health sector. Important and enduring achievements include boosting the capacity of the MOHS by restructuring its organizational structure, hiring and rehiring personnel, revamping its planning and budgeting functions and training its staff. A National Health Accounts system was and a Health Management Information System were initiated in 2007 with the support of the project that provides the potential for monitoring and evaluating the health status of the population, for disease surveillance and provided the data for the M&E component of the Bank financed project. These achievements are not reversible and augur well for the long-term capacity of the MOHS. In 2008, a PER was conducted covering health and other sectors.

(c) Other Unintended Outcomes and Impacts (positive or negative)

66. Three positive unintended results of the projects should be cited. First, it became evident early on that the three priority technical programs (malaria, tuberculosis, and sanitation) required to be expanded and other infectious diseases such as onchocerciasis and that disease surveillance had to be put in place to prepare for a potential Avian Influenza epidemic. Second, the project's support to NGOs and the not-for-profit private sector expanded the range of expertise to address the key causes of the burden of disease and complemented the efforts in building up the public sector capabilities. Third, the project helped tilt public spending towards a pro-poor orientation and supported a decentralization policy that minimized leakages in the flow of funds between the central level and the districts.

3.6 Summary of Findings of Beneficiary Survey and/or Stakeholder Workshops

67. The MOHS organized a large participatory review and planning process that included district personnel, donors, international and local NGOs. The latter continued to

participate in the district and national planning and review processes during project implementation and will remain active after project closing.

4. Assessment of Risk to Development Outcome
Rating: **Moderate**

68. Several project outcomes were successful in effecting behavior change. These changes are very likely not reversible and are positive contributions to the health of the citizens of Sierra Leone. This is the case, inter alia, for the use of insecticide-treated bed nets and the custom of sleeping under these bed nets especially children and pregnant women; the complete immunization of children aged 12-23 months; and the treatment of tuberculosis under a DOTS strategy. Several of the institution building outcomes will also have a staying power, e.g. trained staff, disease surveillance supported by laboratories and a HMIS, the structure and functions of the MOHS, the use of NGOs in reaching health goals, and the coordination of the inputs of all development partners.

69. There are, however, important concerns about the sustainability of the measures that were established during the project's implementation period. MOHS staff, i.e. the integrated PIU, that were paid by the project are now receiving a government salary and their motivation and intention to remain on the job may be uncertain. It is not clear whether the positive outcomes obtained in the four project supported districts may not be replicated as intended to all districts and these "World Bank Districts" may not have the anticipated generalizing effect. Exception measures that were justifiable during the early post conflict years - such as paying staff with external funds - may not apply any longer. However, weighing the results achieved and especially the behavior change, with the uncertainties of going forward tilts the balance in favor of a moderate risk to the development outcomes.

5. Assessment of Bank and Borrower Performance

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry

Rating: **Satisfactory**

70. Several important steps taken at the outset ensured a quality starting point: (a) the project was anchored on the Transitional Support Strategy that included the Bank's business plan; (b) grant financing was appropriate in a post-conflict situation (as well as the waiver of counterpart funds later on); (c) a large participatory review and planning process that included district personnel, donors, international and local NGOs was organized; (d) PHRD and PPF financing produced a large number of key preparatory studies; (e) integrating the PIU in the MOHS was positive; and (f) the selection of mid-size districts emphasized the rural population and the poor.

71. Processing of the credit and the additional financing was completed in a timely manner. Elapsed time between the first Bank mission and Appraisal was 13 months

followed by Negotiations one month later, Board approval two months after negotiations and credit effectiveness within 90 days after Board approval. The Project Paper on the proposed additional financing presented succinctly the rationale for restructuring, the proposed changes and the expected outcomes. An impressive number of ten peer reviewers commented on the Project Concept Document although only one peer reviewer submitted comments on the PAD.

72. Project preparation for both the original credit and the additional financing succeeded in establishing many of the principal elements for project implementation (e.g. a Project Operations Manual, Social Assessment, a Public Expenditure Review for the health sector; a Health Facility Inventory and a Human Resources Assessment). Peer reviewers had cautioned regarding the key performance indicators that it was doubtful that the project would have a measurable impact on IMR, CMR and MMR. Nonetheless these indicators remained in the PAD but were subsequently not included in Schedule 6 of the DGA or in the ISRs.

73. Arrangements for M&E were not detailed in the PAD. The project design summary (Annex 1 of the PAD) stated the data collection strategy and the critical assumptions for obtaining the data in a summary and columnar format. The main text of the PAD should have presented in more detail what baseline was available and for the missing baseline data how, when and by whom it would be obtained.

(b) Quality of Supervision

Rating: **Moderately satisfactory**

74. Given the need to rebuild the institutions after the civil war, the need for intensive supervision was identified early on in the preparation process. Twenty ISRs were prepared and filed during the six and a half years of project implementation. The mid-term review was organized as planned in February 2006. The ICR process was initiated during the last implementation support mission in December 2009 with an ICR mission in early January 2010, and the timelines agreed for the preparation of the government's contribution to the ICR, the submission of the draft ICR for government's comments and the review of the ICR and completion. In the last two years of the project, the Bank team strengthened supervision through: (i) monthly videoconferences when the TTL was not in country; and (ii) weekly meetings with the project team and the Minister when the TTL, procurement and financial management specialists were all based in country, addressing issues as soon as they arose, providing hands-on support on a daily basis. This significantly helped improve the quality and timeliness of project implementation.

75. Financial management was supervised closely and rated uniformly satisfactory for the first four years of project implementation and then changed to moderately satisfactory for the remaining two years. Procurement plans were cleared by the Bank and supervision teams supported the implementation of the country's procurement reform to reduce opportunities for corruption and to improve the efficiency of public spending through fair and open competition. The UN system was used to procure vehicles and to process letters of credit.

76. The task team actively encouraged the Government to construct dumpsites to meet the site specific environment impact assessment, but the project was only able to finance the preparation of technical specifications before project closing.

77. Every supervision mission visited all project districts and inspected the civil works in all PHUs and district hospitals. The government project implementation team also visited project districts regularly. There was a supervising consultant with staff at every construction site on a full time basis. The TTL changed three times during the first three years of project implementation (2003 to 2005). This is a major weakness as the need for continuity is greatest in a rebuilding period when important policy decisions are made, staff is to be trained and smooth relationships between the Bank and the client are important. TTL continuity improved greatly as the same TTL who assumed that function in July 2006 carried the project forward to its successful end. The frequent change in TTLs may account for the roller coaster ratings in the ISRs. The number of indicators varies between the DGA (10), the annex to the project paper (15) and the final ISR(16) .

(c) Justification of Rating for Overall Bank Performance

Rating: **Satisfactory**

78. The Task Team's design of the initial project and the additional financing proposal, its encouragement of specific Government initiatives (decentralization, pro-poor public spending, coordination of donor programs and their alignment with the Government program, boosting of the planning and budgeting capacity of the MOHS, etc.), its flexibility in responding to changes in the project implementation environment, and its continuing frank dialogue with the Government - but mainly in the second half of the project - were all satisfactory. Notwithstanding some weaknesses in supervision especially in the first three years, the lesser degree of supervising district activities and the turnover in TTLs, Bank performance justifies a *satisfactory* rating.

5.2 Borrower Performance

(a) Government Performance

Rating: **Moderately Satisfactory**

79. As already indicated, the Government contributed to many positive aspects to rebuild their public institutions and to partner with the NGOs and the private sector. Government policy reflected the reality that redressing inequities between the capital and the rest of the nation was central to maintaining peace. The role of local councils to achieve equity was acknowledged and a mechanism of formula-based grants was implemented. Government accepted to work with and through some UN agencies to augment its own embryonic capabilities. The Government introduced a number of proactive reforms in public financial management including public procurement that were meant to reduce the opportunities for corruption. The Public Procurement Act covers all procurement in the public sector and creates an autonomous regulator empowered to set

rules and oversee public procurement practices by all public sector bodies. Challenges remained in disseminating the regulations, training Government staff, tying procurement plans into the budgeting process and auditing main spending entities.

(b) Implementing Agency or Agencies Performance

Rating: **Moderately Satisfactory**

80. The MOHS was the implementing agency contracting out some activities to NGOs and other not-for-profit private sector entities. The MOHS had succeeded in implementing the previous credit satisfactorily in spite of the difficult conditions that prevailed in the country from 1995 to 2001. Project preparation was carried out with the full participation of other donors and stakeholders. The success with the earlier credit led to the decision to implement the project without creating a Project Implementation Unit (PIU). This decision met with the approval of the Bank as it is aligned with its policies. However two caveats are in order. First, the PIU of about 15 staff was paid out of credit funds making them de facto "World Bank subsidized employees" with better working conditions and higher pay than the rest of the MOHS staff. Second, by integrating the unit within the structure of MOHS - prima facie a felicitous measure - the unit is subject to all bureaucratic restrictions prevalent in the public sector environment. This was most evident in the processing of procurement that was fraught with administrative delays and interference, especially in the last two years. This compelled the Bank team to advise that all major procurement be carried out through UNICEF. Despite this measure, it was still difficult to obtain approvals and clearances along the procurement chain. The Government team was not responsive to the problem of sub-standard goods and equipment procured under the project despite efforts by the Task Team and the CMU in resolving the issue. Financial management on the other hand was consistently rated satisfactory with audits submitted on time and audit opinions being unqualified. The overall disbursement by project closing was 95 percent.

(c) Justification of Rating for Overall Borrower Performance

Rating: **Moderately Satisfactory**

81. The Moderately Satisfactory performance of the Government and the Moderately Satisfactory performance of the Implementing Agency yield an overall rating of Moderately Satisfactory.

6. Lessons Learned

82. Exit Strategy. More thought needs to be given to the general idea of ‘exit’ strategies. The opportunity for ‘exit’ starts at the design phase and continues by managing effective transition strategies and assisting the Government to transform such transitional arrangements into longer-term capacity development and performance.

83. A PIU or not a PIU. When the Bank needs to help design a project in a post-conflict environment, it makes sense to design a management structure adapted to the prevailing conditions. In most situations, Bank strategy is correct to recommend not creating a separate and independent unit to implement a project. This project did not create a PIU *de jure* and was congratulated for the approach in the design. However a PIU existed de facto as a large group of ministry staff were paid out of the credit. However, this made sense as the war had just ended and there were very few staff so the project actually helped to strengthen the Ministry with the additional staff recruited. They worked both on the project and on other tasks of the Ministry. All of them are still working in the Ministry. As in all PIUs, the negative side is that PIU staff were looked upon as privileged staff by their colleagues who received a lower pay.

84. Post-conflict Environment. Contextual factors at the time of project preparation are not well understood and project design usually takes place in conditions of great uncertainty and complexity. Feasibility of proposed objectives and interventions emerge during implementation. In these conditions, task teams need to be flexible, provide hands-on support and stay the course. Turnover of Bank staff is not helpful to achieving these objectives as a robust rapport with the client is crucial and interpersonal relations play an important role. The conventional techniques of results-based management including planning, prediction, control and targeting need to be adapted to a weak institutional environment. This being said, since 2006 the Bank task team has been very flexible and helped the project implementation team as much as possible, and that contributed to the project's positive outcomes as much as the rules of the Bank would allow and that helped achieve what was achieved.

85. Grant Financing. Grant financing was justified by the urgent need to restore a functioning health sector, its strong development impact and as a means to draw greater and broader support for the sector from other development partners.

86. Sustainability. It should be recognized that until economic development takes off, the funding of the health sector will continue to largely depend upon donor funding. The present credit's sustainability cannot be ensured solely by the government until there is substantial macroeconomic development. Aspects of the project requiring continuous funding (civil works/maintenance, training medical personnel, drug supplies) raise issues of sustainability over the long run, in case of diminishing support from donors.

87. Health Workers. A shortage of health workers is a perennial problem in most African countries, especially in rural areas, and no satisfactory solutions have been found. The exodus of skilled health workers during the civil war exacerbated the problem in Sierra Leone. The country was also not immune from the recruiting practices of developed countries.

88. Capacity Development. Working in post-conflict states makes more demands on donor capabilities to support capacity development. Country teams need to develop more country and sector knowledge, customize capacity development interventions, coordinate with other donors and encourage experimentation and learning. The commitment and

drive of leaders is clearly critical and turnover at the top level can be destabilizing. Most public sector organizations have a ‘missing middle’ which is the group that does the real implementation and that connects the top of the structure to the lower levels. Without that group, capacity development as a process of change loses traction and the ability to move forward.

7. Comments on Issues Raised by Borrower.

None.

Annex 1. Project Costs and Financing

(a) Project Cost by Component (in USD Million equivalent)

Components	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)
RESTORING ESSENTIAL HEALTH SERVICES	13.62	15.02
STRENGTHENING PUBLIC AND PRIVATE SECTOR CAPACITY	5.32	5.98
ONCHO	0.00	2.70
AVIAN FLU	0.00	0.40
WORKS SCALE UP	0.00	4.75
Total Baseline Cost	18.94	28.85
Physical Contingencies	0.57	0.00
Price Contingencies	1.49	0.00
Total Project Costs	21.00	28.85
Front-end fee PPF	0.00	0.00
Front-end fee IBRD	0.00	0.00
Total Financing Required	21.00	28.85

(b) Financing

Source of Funds	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)
Borrower	1.00	1.00
IDA GRANT FOR POST-CONFLICT	20.00	20.00
IDA Additional Financing		7.85[5]
Total Financing	21.00	28.85

[5] Total additional financing of US$8 million equivalent was not fully disbursed.

Annex 2. Outputs by Component

Activity	Beneficiary	Component	Objective
Component 1			
1.2.7.1.Contruction of Makeni Government Hospital	Bombali district	1	Improve access to health care
1.2.7.2. Rehabilitation of Koidu Government Hospital	Kono District	1	Improve access to health care
1.2.7.3. Rehabilitation of Kabala Government Hospital	Koinadugu District	1	Improve access to health care
1.2.7.4. Rehabilitation of Moyamba Government Hospital	Moyamba district	1	Improve access to health care
1.2.8.1. Construction of Taiama Health Center	Moyamba district	1	Improve access to health care
1.2.8.2. Construction of Shenge Health Center	Moyamba district	1	Improve access to health care
1.2.8.3. Construction of Gbangbatoke Health Center	Moyamba district	1	Improve access to health care
1.2.8.4. Construction of Kondebaia Health Center	Koinadugu District	1	Improve access to health care
1.2.8.5. Construction of Mongo Health Center	Koinadugu District	1	Improve access to health care
1.2.8.6. Construction of Sinkunia Health Center	Koinadugu District	1	Improve access to health care
1.2.8.7. Construction of Kamawonie Health Center	Bombali district	1	Improve access to health care
1.2.8.8. Construction of Mabunduka Health Center	Bombali district	1	Improve access to health care
1.2.8.9. Construction of Hundowa Health Center	Bombali district	1	Improve access to health care
1.2.8.10. Construction of Njala Health Center	Kono District	1	Improve access to health care
1.2.8.11. Construction of Motema Health Center	Kono District	1	Improve access to health care
1.2.8.12. Construction of Saiama Health Center	Kono District	1	Improve access to health care
1.2.9. Construction of store for Malaria Control Program	Malaria Program	1	Improve storage situation
1.2.10. Construction of store for ENVSAN Program	Environmental Health Unit	1	Improve storage situation
1.5.1. Construction of civil works - additional facilities at Hospitals and health centres.	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve working condition of staff
1.5.2. Procurement of Furniture and equipment for wards	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to quality health care
1.5.3. Procurement of Furniture and equipment for administrative buildings	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to quality health care
1.5.4. Procurement of specialized medical equipment for hospitals	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to quality health care
1.5.5. Procurement of solar systems for Hospitals and health centres	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to quality health care

Activity	Beneficiary	Component	Objective
1.5.6.Procurement of goods for Onchocerciasis Program	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to quality health care
1.5.7. Procurement of goods for Avian Flu	Directorate of Disease Prevention and Control	1	Improve access to quality health care
1.5.8. TA for Design and supervision of additional works	Civil works consultant	1	Improve access to quality health care
1.5.10. Onchocerciasis consultancy fees and training	Onchocerciasis Control program	1	Strengthen Onchocerciasis control
1.5.11. Avian Flu consultancy fees and training	Directorate of Disease Prevention and Control	1	Strengthen Avian Flu control
1.5.12. Onchocerciasis operating costs	Onchocerciasis Control program	1	Improve access to quality health care
1.5.13. Avian Flu operating costs	Directorate of Disease Prevention and Control	1	Improve access to quality health care
5.1.9. Renovation and furnishing of offices	Environmental Health Unit	1	Strengthen environmental health
5.1.10. Procurement of 4WD vehicle	Environmental Health Unit	1	Strengthen environmental health
5.1.11. Procurement of 2 motorbikes	Environmental Health Unit	1	Strengthen environmental health
6.1.1. Training of 30 Public Health Aides (PHAs)	Environmental Health Unit	1	Strengthen capacity for environmental health management
6.1.2. Reorientation and sensitization of 30 community members on basic ES	Environmental Health Unit	1	Strengthen capacity for environmental health management
6.1.3. Training of 100 women in slum/ squatter settlements on basic hygiene	Environmental Health Unit	1	Strengthen capacity for environmental health management
6.1.6. Review, update, print, launch and distribute the National Environmental Policy.	Environmental Health Unit	1	Strengthen capacity for environmental health management
6.1.8. Assessment of Port Health Offices country wide	Environmental Health Unit	1	Strengthen capacity for environmental health management
6.1.10. Micro-planning workshop with DHS, EHOs on the decentralization of EH activities to district Municipal councils.	Environmental Health Unit	1	Strengthen capacity for environmental health management

Activity	Beneficiary	Component	Objective
6.2.1. Training on health care waste management (NGOs, public health care staff, private health care staff, paramedical staff)	Environmental Health Unit	1	Strengthen capacity for environmental health management
6.2.2. Training of Technicians to operate medical waste management equipment in health care facilities (25 participants)	Environmental Health Unit	1	Strengthen capacity for environmental health management
7.1.1. Recruit Program Administrator	National Malaria Control Program	1	Strengthen capacity of malaria control
7.1.2. International TA to strengthen management	National Malaria Control Program	1	Strengthen capacity of malaria control
7.1.3. Recruitment of national consultants	National Malaria Control Program	1	Strengthen capacity of malaria control
7.1.4. Regional training on epidemiology	National Malaria Control Program	1	Strengthen capacity of malaria control
7.1.5. Refresher training of laboratory technicians	National Malaria Control Program	1	Strengthen capacity of malaria control
7.1.6. Office equipment, furniture and supplies	National Malaria Control Program	1	Strengthen capacity of malaria control
7.2.1. Production of training materials on case management	National Malaria Control Program	1	Strengthen capacity of malaria control
7.2.2. TOT on malaria case management/ IMCI (25 participants)	National Malaria Control Program	1	Capacity building in malaria case management
7.2.3. Training of clinical staff on malaria case management	National Malaria Control Program	1	Capacity building in malaria case management
7.2.4. TA to produce training materials for Community Health Workers	National Malaria Control Program	1	Capacity building in malaria case management
7.2.5. Training of community representatives on Standard Case Management (50 participants)	National Malaria Control Program	1	Capacity building in malaria case management
7.2.6. Sentinel surveillance for drug efficacy (in 2 districts hospitals of 4 Project Districts)	National Malaria Control Program	1	Capacity building in malaria case management
7.2.7. Provide anti-malarials	National Malaria Control Program	1	Improve malaria case management
7.3.1. Provision, marketing and distribution of ITNs (contract)	National Malaria Control Program	1	Improve malaria case management
7.3.3. Continuous Health Education/ IEC community mobilization for Malaria Prevention	National Malaria Control Program	1	Improve malaria case management
8.1.1. Recruit Program Administrator	TB and Leprosy Control Program	1	Strengthen capacity for TB control
8.1.2. Workshop to develop joint action plan	TB and Leprosy Control Program	1	Strengthen capacity for TB control
8.1.3. Support for implementation/ coordination of joint action plan	TB and Leprosy Control Program	1	Strengthen capacity for TB control
8.1.4. Procure Office equipment, furniture and supplies	TB and Leprosy Control Program	1	Strengthen capacity for TB

Activity	Beneficiary	Component	Objective
			control
8.1.6. Incentives for field staff (Sister, CHO, Field Supervisor, Assistant Supervisor, Laboratory Assistant, Treatment Officer, Driver)	TB and Leprosy Control Program	1	Strengthen capacity for TB control
8.2.1. Conducting of advocacy meetings with communities and DHMTs	TB and Leprosy Control Program	1	Strengthen TB control
8.2.3. Survey of health facilities re TB	TB and Leprosy Control Program	1	Strengthen TB control
8.2.6. IEC campaign implementation	TB and Leprosy Control Program	1	Strengthen TB control
8.2.7. Support for World TB Day activities	TB and Leprosy Control Program	1	Strengthen TB control
8.2.8. Printing of M&E forms	TB and Leprosy Control Program	1	Strengthen TB control
8.2.9. Supervision of clinical and lab staff	TB and Leprosy Control Program	1	Strengthen TB control
8.2.10. Refresher workshop for medical officers on TB (20 participants)	TB and Leprosy Control Program	1	Strengthen TB control
8.2.11. Workshop for paramedical officers on TB (20 participants)	TB and Leprosy Control Program	1	Strengthen TB control
8.2.12. Workshop for nurses on TB (20 participants)	TB and Leprosy Control Program	1	Strengthen TB control
8.2.13. Orientation of HC staff on TB (30 participants)	TB and Leprosy Control Program	1	Strengthen TB control
8.2.14. Attend conferences, meetings and workshops (2 participants)	TB and Leprosy Control Program	1	Strengthen TB control
8.2.15. Establishment of DOTS centers in chiefdoms of project beneficiary districts.	TB and Leprosy Control Program	1	Strengthen TB control
8.3.1. Provide microscopes, furniture, supplies and reagents	TB and Leprosy Control Program	1	Strengthen TB control
8.3.2. Refresher workshop for lab assistants on TB	TB and Leprosy Control Program	1	Strengthen TB control
9.1.1. Conducting of community sensitization and mobilization for CDTI	Onchocerciasis Control Program	1	Strengthen Onchocerciasis control
9.1.2. Training of 800 Nurses and PHU staff on CDTI	Onchocerciasis Control Program	1	Strengthen Onchocerciasis control
9.1.3. Conducting of CDD training	Onchocerciasis Control Program	1	Strengthen Onchocerciasis control
9.1.4. Distribution of Ivermectin	Onchocerciasis Control Program	1	Strengthen Onchocerciasis control
9.1.5. Conducting of monitoring and supervision Data collection and Analysis.	Onchocerciasis Control Program	1	Strengthen Onchocerciasis control
9.1.6. Conducting of annual review and prize giving.	Onchocerciasis Control Program	1	Strengthen Onchocerciasis control
9.2.1. Procurement of 5 Toyota Hilux 4WD	Onchocerciasis Control Program	1	Strengthen Onchocerciasis control
9.2.2. Procurement of 2000 bicycles	Onchocerciasis Control Program	1	Strengthen Onchocerciasis control
9.2.3. Procurement of 10 motorbikes	Onchocerciasis Control Program	1	Strengthen Onchocerciasis control
9.2.4. Procurement of 1000 bicycles	Onchocerciasis Control Program	1	Strengthen Onchocerciasis control

Activity	Beneficiary	Component	Objective
10.1.2. Equipment, furniture and supplies for renovated CHCs	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
10.1.3. Equipment, furniture and supplies for M&E office	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
10.1.4. Laboratory equipment and supplies	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
10.1.5. Essential Drugs	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
10.1.6. Supplementary food for vulnerable groups	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
10.1.7. Support for health education activities	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
10.2.2. Training on health waste management in health centers	Moyamba, Bombali, Koinadugu and Kono districts	1	Improve access to services
10.2.3. Supplies for health waste management (bags, gloves, etc.)	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
10.2.4. Operating costs for incinerators and septic tanks	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
10.3.1. Training of PHU staff on emergency obstetric care and life - saving skills	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
10.3.2. Training of PHU staff on IMCI	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
10.3.3. Provision of Solar Panels for delivery rooms in PHUs	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
11.1.2. Equipment, furniture and supplies for renovated CHCs	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
11.1.3. Equipment, furniture and supplies for M&E office	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
11.1.5. Procure essential drugs	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
11.1.7. Support for Health Education activities	Moyamba, Bombali, Koinadugu and	1	Improve access to services

Activity	Beneficiary	Component	Objective
	Kono Districts		
17.1.1. Design/Supervision of hospital rehabilitation	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
17.1.2. Procurement of hospital furniture and equipment	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
17.1.3. Procurement of specialized and essential drugs	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
17.1.4. Study tour for hospital board members on hospital Management.	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
17.1.5. Training of hospital staff on the management of common communicable diseases	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
17.1.6. Provision of oxygen concentrators for pediatric and maternity wards	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
17.1.8. Operational costs (stationery, fuel, maintenance etc.)	Moyamba, Bombali, Koinadugu and Kono Districts	1	Improve access to services
Additional Facilities at Kabala Government Hospital	Koinadugu District	1	Improve access to services
Additional Facilities at Makeni Government Hospital	Koinadugu District	1	Improve access to services
Additional Facilities at Moyamba Government Hospital	Koinadugu District	1	Improve access to services

Component 2			
1.1.1. Publication of the revised National Health Policy (500 copies)	DPI	2	Provide a National Health Policy
1.1.2. Support to Sierra Leone Medical and Dental Association (SLMDA) for annual meeting	SLMDA	2	Contribution towards quality service delivery
1.1.3. Support to Sierra Leone Nurses' and Midwives' Association (SLNMA) for annual meeting.	SLNMA	2	Contribution towards quality service delivery
1.1.4. Support to Sierra Leone Medical and Dental Council (SLMDC) for annual meeting.	SLMDA	2	Contribution towards quality service delivery
1.1.5. Support for Traditional Medical Association	SLATMP	2	Contribution towards quality service delivery
1.2.1. Architect recruited	Architectural Services Unit	2	Strengthen civil works
1.2.2. Assistant Architect recruited	Architectural Services Unit	2	Strengthen civil works
1.2.4. Supervision of construction of 4 district Hospitals and 12 Community Health Centers.	Architectural Services Unit	2	Improve quality of civil works
1.2.5. Attended international conferences, seminars and workshops	Architectural Services Unit	2	Strengthen civil works
1.2.11. Procurement of vehicle for country-wide supervision of Civil Works (Assistant Architect)	Architectural Services Unit	2	Strengthen civil works
1.2.12. Surveying and registration of land around 4 hospitals and 12 CHC.	Architectural Services Unit	2	Improve access to health care
1.3.1. Recruitment of Procurement Specialist	Procurement Unit	2	Strengthen procurement unit
1.3.2. Recruitment of Assistant Procurement Specialist	Procurement Unit	2	Strengthen procurement unit
1.3.3. Recruitment of Procurement Clerk	Procurement Unit	2	Strengthen procurement unit
1.3.4. Recruitment of Procurement Secretary	Procurement Unit	2	Strengthen procurement unit
1.3.5. Procurement of office equipment and supplies	Procurement Unit	2	Strengthen procurement unit
1.3.6. Procurement of 4WD vehicle for Procurement Unit	Procurement Unit	2	Strengthen procurement unit
1.3.7. Training of staff on Procurement Guidelines	Procurement Unit	2	Strengthen procurement unit
1.3.8. Attend international conferences, training, seminars and workshop etc.	Procurement Unit	2	Strengthen capacity in procurement unit
1.3.9. Procurement training for District Finance Officers	Procurement Unit	2	Strengthen district procurement capacity
1.3.10. Conducting of one day workshop to finalize procurement plan	Procurement Unit	2	Strengthen capacity in procurement unit
1.4.1. Recruitment of Donor/NGO Liaison Officer	Donor/NGO Liaison Officer	2	Strengthen NGO/Donor coordination
1.4.2. Recruitment of Assistant Donor/NGO Liaison Officer	Donor/NGO Liaison Officer	2	Strengthen NGO/Donor coordination
1.4.3. Data collection and survey on Donor/NGO activities and project	Donor/NGO Liaison Officer	2	Strengthen NGO/Donor coordination
1.4.4. Periodic meetings for donors and NGOs	Donor/NGO Liaison Officer	2	Strengthen NGO/Donor coordination
1.4.5. Monitoring and supervision of NGO activities countrywide	Donor/NGO Liaison Officer	2	Strengthen NGO/Donor coordination

1.4.6. Produce handbook on donors and NGOs	Donor/NGO Liaison Officer	2	Strengthen NGO/Donor coordination
1.4.7. Produce Newsletter for the Ministry and health sector	Donor/NGO Liaison Officer	2	Improve information dissemination
1.4.8. TA for development and management of website	MOHS	2	Improve information dissemination
1.4.9. Training on website management	MOHS	2	Improve information dissemination
1.4.10. Attend international conferences, meetings, trainings and workshops.	Donor/NGO Liaison Officer	2	Strengthen NGO/Donor Coordination
1.4.11. Procurement of office furniture, equipment and supplies	Donor/NGO Liaison Officer	2	Strengthen NGO/Donor coordination
1.4.12. Procurement of vehicle for Donor/ NGO Liaison Office	Donor/NGO Liaison Officer	2	Strengthen NGO/Donor coordination
2.1.1. Recruit Planning Director	Directorate of Planning and Information.	2	Strengthen DPI
2.1.2. Recruit Health Economist	Directorate of Planning and Information.	2	Strengthen DPI
2.1.3. Short-term training in health economics and financing.	Directorate of Planning and Information.	2	Strengthen DPI
2.1.4. Annual revision/reproduction of the planning guidelines and directives	Directorate of Planning and Information.	2	Improve Health planning
2.1.5. District-level training on data collection and report-writing	Directorate of Planning and Information.	2	Improve information systems
2.1.6. Printing of forms	Directorate of Planning and Information.	2	Improve information systems
2.1.7. Procurement of office furniture, equipment and supplies	Directorate of Planning and Information.	2	Strengthen DPI
2.1.8. Attend International conferences, trainings, meetings and workshops.	Directorate of Planning and Information.	2	Improve Health planning
2.1.9. Regular consultative meetings on the implementation of cost recovery with Program Managers and DHMTS (Quarterly)	Directorate of Planning and Information.	2	Improve cost recovery
2.1.11. Conduct District/ regional preparatory planning and budgeting workshops	Directorate of Planning and Information.	2	Improve Health planning
2.1.12. Annual National Health Review and Planning	Directorate of Planning and Information.	2	Improve Health planning
2.1.13. Printing of final, updated version of PHC Operational Handbook	Directorate of Planning and Information.	2	Improve district operations
2.1.14. Conduct Consultative meetings on decentralization	Directorate of Planning and Information.	2	Facilitate smooth devolution of health activities
2.2.1. Recruit Medical Statistician	Directorate of Planning and Information.	2	Strengthen DPI

2.2.2. Recruit Monitoring and Evaluation Specialist	Directorate of Planning and Information.	2	Strengthen DPI
2.2.3. Attend international conferences, seminars and workshops	Directorate of Planning and Information.	2	Strengthen DPI
2.2.4. Training of M and E Officers in the use of Computerized Data Base for Health Management Information System.	Directorate of Planning and Information.	2	Improve HIS for decision making
2.2.5. Support Districts to conduct cascade training on the use of revised PHU and new hospital forms	Directorate of Planning and Information.	2	Improve HIS for decision making
2.2.7. Support MCH module for Core Welfare Indicators (addition to SSL's CWIQ) survey	Directorate of Planning and Information.	2	Support availability of data
2.2.8. Short - term training for Medical Statistician.	Directorate of Planning and Information.	2	Strengthen DPI
2.2.9. Recruitment of driver for Medical Statistician	Directorate of Planning and Information.	2	Strengthen DPI
2.2.10. Procurement of 4WD vehicle for M & E Specialist	Directorate of Planning and Information.	2	Strengthen DPI
2.2.11. Procurement of 5 motorcycles to strengthen M & E.	Directorate of Planning and Information.	2	Strengthen DPI
2.2.12. Production of guidelines/manual on the use of Hospital data collection forms and registers.	Directorate of Planning and Information.	2	Improve data collection
2.2.13 Train health care workers in use of data collection forms	Directorate of Planning and Information.	2	Improve data collection
2.2.14. Print data collection forms	Directorate of Planning and Information.	2	Improve data collection
2.3.1. Update database on the distribution of health care facilities in the country.	Directorate of Planning and Information.	2	Improve data collection
2.3.2. Develop GIS map with distribution of health care facilities country-wide	Directorate of Planning and Information.	2	Provide maps for improved planning
2.4.1. National sensitization on the National Health Account (NHA) and identification of health care providers.	Directorate of Planning and Information.	2	Support planning
3.1.1. Recruit Director of Financial Resources	Directorate of Planning and Information.	2	Strengthen financial management
3.1.2. Recruit Management Accountant	Directorate of Planning and Information.	2	Strengthen financial management
3.1.3. Publish revised accounting manual	Directorate of Planning and Information.	2	Strengthen financial management
3.1.4. Printing of Integrated annual draft budget.	Directorate of Planning and Information.	2	Strengthen financial management
3.2.1. Train relevant staff on the use of financial Management software.	Directorate of Financial Management	2	Strengthen financial management
3.2.2. Train secretaries and finance staff on computer applications	Directorate of Financial Management	2	Strengthen financial management

3.2.3. Short-term training on record keeping and budgeting	Directorate of Financial Management	2	Strengthen financial management
3.2.4. Formal training of Finance Officers on Double Entry, Book Keeping and Bank Reconciliation.	Directorate of Financial Management	2	Strengthen financial management
3.2.5. Conduct Regional budgeting workshops	Directorate of Financial Management	2	Strengthen financial management
3.2.6. Training of Finance Officers and Program Managers on liquidation of workshop expenses.	Directorate of Financial Management	2	Strengthen financial management
3.2.7. Training for Graduate Accountant in public sector accounting and budgeting (IPAM)	Directorate of Financial Management	2	Strengthen financial management
3.2.8. Training of Finance Officers in public sector accounting & budgeting.	Directorate of Financial Management	2	Strengthen financial management
3.2.9. Attend international conferences, seminars and workshops	Directorate of Financial Management	2	Strengthen financial management
3.2.10. Regional workshop in stock keeping and accounting	Directorate of Financial Management	2	Strengthen financial management
3.2.11. Incremental allowances for Support Staff .	Directorate of Financial Management	2	Ensure job satisfaction
3.2.12. Recruitment of additional support staff (two Drivers and Six Secretaries)	Directorate of Financial Management	2	Strengthen management
3.3.2. Operational costs (Telephone bills, stationery, vehicle and equipment maintenance, fuel, etc.)	Directorate of Financial Management	2	Strengthen management
3.3.3. Retainer for maintenance and repairs of computers and accessories.	Directorate of Financial Management	2	Strengthen management
3.4.1. Procurement of vehicles for country-wide monitoring and supervision.	Directorate of Financial Management	2	Strengthen management and supervision
3.4.2. Procurement of office equipment, furniture and supplies.	Directorate of Financial Management	2	Strengthen financial management
3.4.3. Furnishing of offices for finance officers in Bombali, Koinadugu, Kono, and Moyamba.	Directorate of Financial Management	2	Strengthen financial management
3.4.4. Procurement of equipment for Financial Management Unit (FMU)	Directorate of Financial Management	2	Strengthen financial management
3.5.1. Conducting of consultative workshop on drug cost recovery management at regional level.	Directorate of Financial Management	2	Strengthen financial management
3.6.1 Revise the financial management system of the Ministry taking into consideration all sources of funds.	Directorate of Financial Management	2	Strengthen financial management
3.6.2 Assistance with financial management decentralization	Directorate of Financial Management	2	Strengthen financial management
3.6.3. Computerized budgeting accounting and software for the ministry - final payment.	Directorate of Financial Management	2	Strengthen financial management
Recruit Internal Auditor	Directorate of Internal Audit	2	Strengthen internal audit
Recruit Assistant Internal Auditor	Directorate of Internal Audit	2	Strengthen internal audit

TA for annual audit	Directorate of Internal Audit	2	Strengthen internal audit
5.1.1. Recruit Manager of Human Resources	Human Resources Unit	2	Strengthen HR unit
5.1.2. Support for specialized training (midwifery, anesthesiology, etc.)	Human Resources Unit	2	Strengthen HRH
5.1.3. Support for implementation of the annual in-service training plan	Human Resources Unit	2	Strengthen HRH
5.1.4. Conducting of personnel verification	Human Resources Unit	2	Strengthen HRH
5.1.5. Conduct survey to assess training needs for critical skills	Human Resources Unit	2	Strengthen HRH
5.1.6. Review of HR training policy	Human Resources Unit	2	Strengthen HRH
5.1.7. Training of staff on personnel records management	Human Resources Unit	2	Strengthen HRH
5.1.8. Management of personnel database	Human Resources Unit	2	Strengthen HRH
2.1.15. Procure 4WD vehicle for Health Economist	Directorate of Planning and Information.		Strengthen DPI
2.2.6. Conduct regional workshops to train DHMT members on survey methodology.	Directorate of Planning and Information.		Support availability of data

Annex 3. Economic and Financial Analysis

89. It was agreed during preparation that an economic analysis would not be required. Instead a health sector Public Expenditures Review was carried out during preparation. It was recognized that until economic development takes off, the funding of the health sector will largely depend on donor funding and that the present credit would not be sustainable until there is substantial macroeconomic development. The project invested in activities that have well documented cost effectiveness ratios such as improving basic health services, primary health care, first referral health facilities, human resources development, and support to programs addressing important infectious disease controls (malaria, tuberculosis, onchocerciasis, sanitation). These infectious diseases represent a major economic burden on the country by lowering the productivity of workers and increasing the cost of treatment. Essential services supported by the project are those designated by the Bank as a cost-effective package for low-income countries.

90. Financial issues such as measures for ensuring financial accountability and management of funds generated from cost recovery would be addressed during project implementation. External audit reports and financial analysis of the earlier project implemented by MOHS had been unqualified. The US$1 million in counterpart fund requirement was waived during project implementation and IDA allowed 100% financing of eligible expenditures according to the Country Financing Parameters.

Annex 4. Bank Lending and Implementation Support/Supervision Processes

(a) Task Team members

Names	Title	Unit
Akinrinmola Oyenuga Akinyele	Financial Management Specialist	AFTFM
Johanne Angers	Senior Operations Officer	AFTHE
Ferdinand Tsri Apronti	Procurement Specialist	AFTPC
Andrew Osei Asibey	Sr. Monitoring & Evaluation Specialist	AFTRL
Evelyn Awittor	Senior Operations Officer	AFTHE
Ousmane Bangoura	Consultant	AFTH2 - HIS
Samuel Bruce-Smith	Consultant	AFTFM
Wolfgang M. T. Chadab	Senior Finance Officer	CTRFC
Gregoria Dawson-Amoah	Program Assistant	AFCW1
Robert Wallace DeGraft-Hanson	Financial Management Specialist	AFTFM
Edward Felix Dwumfour	Sr. Environmental Specialist	AFTEN
Astrid Helgeland-Lawson	Sr. Operations Officer	AFTH2
Manush A. Hristov	Sr. Counsel	LEGAF
Jonathan Nyamukapa	Sr. Financial Management Specialist	AFTFM
Oluwole Pratt	Financial Management Analyst	AFTFM
Alexander S. Preker	Lead Economist, Health	CICHE
Laura L. Rose	Sr. Economist (Health)	AFTHE
Pamela O. Sofola	Resource Management Analyst	AFTRM
Frederick Yankey	Sr. Financial Management Specialist	AFTFM
Yongmei Zhou	Sr. Institutional Dev. Spec.	SASDU

(b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	US$ Thousands (including travel and consultant costs)
Lending		
FY02	14	86.88
FY03	19	72.61
FY04		0.00
FY05		0.00
FY06		0.00
FY07		0.00
FY08		0.00
Total:	33	159.49

Supervision/ICR		
FY02		0.00
FY03	17	57.35
FY04	26	116.84
FY05	22	116.96
FY06	21	128.12
FY07	55	156.45
FY08	36	104.84
FY09	24	0.00
Total:	201	680.56

Annex 5. Borrower's ICR

91. **Introduction.** The 10–year civil war devastated most of the health care infrastructure and other social services. In order to help the country rebuild its health care services, the World Bank supported the GOSL with a grant of 20 million US dollars to implement the Health Sector Rehabilitation and Development Project (HSRDP). This 5-year project was specifically designed to help the GOSL in its post-war rehabilitation and development efforts by restoring the most essential functions in the health delivery system.

92. These choices were based on criteria such as health needs, timeliness of the interventions, cost-effectiveness, and a potential positive impact of health interventions on stability and resettlement of the population of certain districts. Some other important considerations were: (i) the size of the financial gap in some areas or, conversely, the support from other donors (such as WHO and UNICEF in safe motherhood, immunizations and nutrition; EU and ADB in drug procurement, stock management and distribution); (ii) the potential for raising grants for activities such as Onchocerciasis and HIV/AIDS; and (iii) a preoccupation with keeping the project relatively simple and doable.

93. The goal of the project was to restore the most essential functions in the health care delivery system of the country. The development objectives of the project were to:

(i) Increase access to essential health services in four districts – Bombali, Koinadugu, Kono, and Moyamba;
(ii) improve the performance of technical programs on Malaria, Tuberculosis, Sanitation and Onchocerciasis;
(iii) strengthen the health sector management capacity to improve efficiency and decentralization; and
(iv) support the development of the private sector and involvement of civil society in decision making.

94. *OBJECTIVE 1: Increase access to essential health services in four districts.* The first specific objective was limited in scope to the four districts which met specific selection criteria (such as importance to the demobilization, resettlement and peace processes; magnitude of the public health problems; clear need to rehabilitate the infrastructure for service delivery, etc.). Within these four districts, the project focused on the rehabilitation of priority health facilities, and support for delivery of affordable and high quality services.

95. *OBJECTIVE 2: Improve performance of technical programs on Malaria, Tuberculosis, Sanitation and Onchocerciasis*. Through this objective, the project sought to reduce the burden of some of the most critical infectious diseases country-wide by giving support to Malaria and TB control activities, and the Sanitation programs.

96. *OBJECTIVE 3: strengthen the health sector management capacity to improve efficiency and decentralization*. The third specific objective aimed to improve efficiency and to make the health sector more responsive to the needs of the population by supporting district health teams country-wide and five key services of the MOHS (i.e. Human Resources Development; Planning, Monitoring and Evaluation; Financial Management; Procurement; and Donor and NGO coordination).

97. *OBJECTIVE 4: support the development of the private sector and involvement of civil society in decision making*. The fourth specific objective was to improve the quality of services by (i) promoting development and regulation of the private sector, strengthening the quality of care and enhancing the contribution of the private sector to the achievement of public health objectives, (ii) providing incentives to health care providers to establish practices in rural areas and smaller cities, (iii) outsourcing clinical and non-clinical services from the private sector, and by (iv) involving the civil society in decision making in the health administration and in health facilities.

98. While the project initially focused on the restoration of health care delivery, it was to provide increased support to the reform process in the health sector, including to cost-recovery and the set up of mechanisms to protect the access of the poorest population to services.

99. The project was effective in February 2003 with a completion date of February 2008. The Mid-term Review was held in February 2006, and since then much progress was achieved in all the four components of the project and the additional new critical areas that were added during the mid-term review.

100. About mid-way through the project, the Government requested additional funding for the following reasons:

- Scale up Onchocerciasis control and prevention (2.8million equivalent)
- Strengthen Avian Influenza awareness and preparedness (0.4 million equivalent)
- Improve operational conditions of health facilities (4.8 million equivalents) – this was needed (i) complete civil works on existing facilities; and (ii) and to construct additional facilities for hospitals and community health centers.

101. In order to incorporate these additional activities, the following changes were made to the project:

- The funding for malaria control activities was reduced**,** including for the promotion and distribution of insecticide-treated bed-nets and other malaria control activities. This was because the Global Fund had started to support those components.
- Key Performance Indicators (KPIs) were revised to better reflect project activities.

Progress With Regards To Project Objectives

102. **Objective 1: Increase access to essential health services in four districts.** Component 1 of HSRDP was to restore some of the most basic health services in the four districts. This component was the main thrust of the project as it focused on rebuilding 16 health facilities in the four districts. With support from the project, 12 peripheral health units, 3 in each of the four districts, were either reconstructed or rehabilitated. Also 3 hospitals were rehabilitated and one new hospital was constructed in Makeni town. Renovation work on the government hospital in Kono was however not fully completed, even though a significant amount of the work was done. The facilities were all equipped with new equipment. The construction of these new facilities has contributed to increasing the proportion of people with access to health care from 60% before the project to over 70%.

103. Additional funds were used to built staff quarters for staff working in the hospitals in Makeni, Kabala and Moyamba. These quarters have served as incentives for qualified staff to work in these hospitals.

104. **Objective 2: improve the performance of the technical programs: Malaria, Tuberculosis, Sanitation and Onchocerciasis.** The HSRDP provided support for 4 key programmes, malaria control, TB control, Waste Management and Onchocerciasis control. With supplemental funding, control of avian flu was also supported.

105. In terms of malaria control, with HSRDP support a total of 160,000 insecticide treated bed nets were procured and distributed in the 4 priority districts. This helped to increase the number of children sleeping under insecticide treated bed nets. Also, staff were trained in the control of malaria, leading to better management of cases. The management of the programme was greatly enhanced as a result of the additional staff that was supported through the project.

106. The support requested for TB control complemented the efforts of government and partners to expand DOTS services in the four districts. The capacity of health staff in the diagnosis and treatment of TB was expanded into the four supported districts. The programme worked with the respective district health management teams (DHMTs) in identifying and establishing diagnostic and treatment centres. Laboratory equipment, furniture and other supplies were procured and distributed to these centres. Community sensitization activities were also carried out in the chiefdoms to improve TB case detection and treatment. Community sensitization was strengthened, leading to an increase in case detection and TB Treatment success rates. Existing DOTS centres were strengthened.

107. **Objective 3: strengthen the health sector management capacity to improve efficiency and decentralization.** With support from HSRDP, the Directorate of Planning and Information (DPI) has been strengthened through the recruitment of key personnel for the unit. The personnel recruited are the Director of Planning and Information, a Monitoring and Evaluation Specialist, the medical statistician and the health economist.

108. In order to make the unit more functional, it has been supported logistically, by the procurement of vehicles, office equipment and supplies. The project supported the following units in the Directorate: Policy and Planning, Health Financing and, Health Information Systems Unit.

109. With regards to health policy and planning, the planning process of the Ministry has greatly improved. The Annual review meetings have helped the Ministry and partners to decide on the way forward in addressing the challenges faced by the Ministry in providing health care. With direction from DPI, in 2009, each district developed its comprehensive health plan based on the needs of the district and included activities of most stakeholders in the health sector working in the district. These plans will contribute not only towards achieving the Millennium Development Goals (MDGs), but will also improve overall health outcomes for the entire population.

110. In order to ensure the proper management of funds received from the cost recovery program, the unit carried out a series of workshops in the 4 HSRDP supported districts. These workshops clearly resulted in better management of the cost recovery funds in the 4 districts.

111. HSRDP support for health information system has helped improve the information system in the entire Ministry. Access to accurate and timely data has greatly improved within the sector. This has contributed to better planning and better decision making within the sector.

112. HSRDP also supported the setting up of a functional internal audit unit in the Ministry. Staff members were trained to perform these functions, and internal control mechanisms were established. The unit has been instrumental in (i) providing invaluable advice on the design, implementation and operation of financial and management control systems; and (ii) identifying opportunities to make cost savings and promote a risk-free and effective internal control culture within the Ministry of Health and Sanitation. The Internal Audit Unit has set up useful mechanisms for ensuring that high-level information on risk and control is brought to the Accounting Officer's attention. It has provided auxiliary support to the work of the Permanent Secretary (Vote Controller) by monitoring and reviewing the risk, control and governance processes which have been established in the organization, as well as associated assurance processes.

113. The Donor NGO Liaison Office was supported by the HSRDP to ensure the coordination and monitoring of all health related partner's activities in line with government policy and plans, and the harmonization of funds. This has helped promote collaborative relationships between all health partners and the Government, and strengthened the dialogue between partners in the health sector. Health partners include Non Governmental Organizations (NGOs), Donors (Multilateral and Bilateral), Charities, Faith-Based Organizations (FBOs) and UN agencies. Coordination, collaboration and communication between partners and the Ministry, has improved considerably and also, most importantly, within the Ministry. This process is commended by partners within and

outside the country, other ministries, regional countries and visitors. The Donor NGO Liaison Office is utilised by partners as the focal point of the Ministry with regards to Donor and NGO activities.

114. HSRDP also supported the Procurement Unit through capacity building and provision of logistics. This helped improve procurement processes within the Ministry and ensured that the procurement of goods and services was transparent, competitive and credible.

115. HSRDP support helped the Ministry to prepare Councils to take up their devolved functions and the Manager/Directorate to understand the process and new roles. As a result, health services were among the first decentralized functions that were developed, and the process went on smoothly. The running of district hospitals and community health facilities are now the responsibility of local governments through their local councils. The central government has increased budgetary allocations to councils to enable them better maintain these structures and ensure the regular provision of pharmaceuticals and supplies. Each of the hospitals and the primary health care programmes of the councils have a budget line within their respective local council development budgetary allocations.

116. **Objective 4: support the development of the private sector and involvement of civil society in decision making.** This objective concentrated mainly on supporting the regulatory boards to improve the systems for monitoring the activities of health professions and health institutions.

Lessons Learned During Project Implementation

117. **Objective 1: Increase access to essential health services in four districts.** Several lessons were learned in the implementation of this objective. At the beginning, the process of recruiting contractors for rehabilitating/reconstructing health facilities was carried out principally at the central level of MoHS, with very little involvement of the local communities that were beneficiaries of the facilities. Several delays were experienced, and when communities were later involved in monitoring of the construction activities, much progress was made. Similarly for equipment, most of the contracts were awarded without the involvement of the District teams who were going to use them. As a result, they were not aware of the items that were bought by the project, and hence most of them were not installed in a timely manner. The lesson learned there was that local beneficiaries should be involved in every aspect of the process. This will increase ownership, and introduce another useful control mechanism.

118. **Objective 2: improve the performance of the technical programs: Malaria, Tuberculosis, Sanitation and Onchocerciasis.** The provision of support to only a few selected technical programmes made the HSRDP support somewhat vertical. Other programmes felt left out and vertical systems were established. The lesson learned there is that it is better to support the sector horizontally rather that directing support to individual programmes. For example, training of staff should be across the board, so it is

better to train staff in case management rather than supporting training in only malaria case management. This approach leads to more efficiency and better results.

119. During the implementation of the HSRDP, other partners came onboard to support some of the programmes that were already been supported through HSRDP. Through discussions with these new partners, some of the HSRDP funds were reprogrammed. The lesson learned there is that regular consultation among implementing agencies and partners helps harmonize resources and avoid duplication.

120. **Objective 3: strengthen the health sector management capacity to improve efficiency and decentralization.** The HSRDP provided technical support for central level programmes and Directorates and did not set up a separate PIU. The Technical support to the Ministry served both to manage project and non-project activities. These additional staff were essential for the Ministry to resume its most vital functions and further develop the sector. The lesson learned is that rather than bringing in staff for a separate PIU, it will be better to strengthen the capacity of the Ministry to help carry out the PIU functions.

121. Also, most of the additional staff recruited by the project were paid exclusively from the proceeds of the project. The units in which these workers operated are considered critical outputs of the project which should definitely be sustained, considering the fact that their existence has added value to the Ministry in terms of functionality and competency in playing important roles in terms of governance, leadership and coordination roles. To sustain the gains made by the project, the project staff have now been absorbed into the Ministry. This process however was not easily achieved. The lessons learnt there is that all staff employed by project, should be absorbed into the government payroll at least a year before project closure, so that their functions and gains will be sustained.

122. **Conclusion.** The HSRDP helped restore critical health care services in selected districts and greatly improved the capacity of the Central level MOHS to carry out its oversight functions. The improvement in the planning process has resulted in the development of the First National Health Sector Strategic Plan, the development of comprehensive district plans, the improvement of partner coordination and the movement towards a SWAp, the setting up of functional coordinating structures, the improvement in the health information systems and the strengthening of the financial management system. As a result, the health sector is receiving support from more partners and is looking positively towards attaining the health MDGs.

IBRD 33478


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 P.R.
PORT LOKO
KAMBIA
BOMBALI
KOINADUGU
TONKOLILI
KONO
KAILAHUN
KENEMA
MOYAMBA
BO
BONTHE
PUJEHUN
Falaba
Yana
Kabala
Bendugu
Kamakwie
Fadugu
Madina Junction
Kambia
Pendembu
Batkanu
Bumbuna
Alikalia
Kurubonla
Kamaron
Gbinti
Mange
Makeni
Binkolo
Kayima
Port Loko
Lunsar
Magburaka
Matotoka
Tefeya
Yengema
Sefadu
Lungi
Pepel
Masiaka
Masingbi
Njaiama-Sewafe
Gandorhun
Songo
Waterloo
Yonibana
Yele
Koindu
Buedu
Kailahun
Rotifunk
Moyamba
Mongeri
Dambara
Panguma
Mano
Bo
Lago
Pendembu
Daru
Shenge
Sembehun
Blama
Kenema
Kribundu
Joru
Momaligi
Matru
Sumbuya
Potoru
Bonthe
Pujehun
Zimmi
Fairo
Sulima
Wara Wara Mts.
Loma Mts.
Gori Hills
Bintimani (1948 m)
Great Scarcies
Little Scarcies
Rokel
Pampana
Seli
Bagbe
Mongo
Jong
Sewa
Moa
Mano
Kittam
Sherbro
Sherbro Island
Turtle Islands
Banana Islands
Yawri Bay
Lake Mabesi
Lake Mape
To Kindia
To Ouré-Kaba
To Faranah
To Forecariah
To Kolahun
To Monrovia
SIERRA LEONE
0 20 40 60 Kilometers
0 20 40 50 Miles
13°W
12°W
11°W
10°N
9°N
8°N
7°N
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