



Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 08-Oct-2021 | Report No: PIDA31541



BASIC INFORMATION

A. Basic Project Data

Country Sierra Leone	Project ID P172102	Project Name Sierra Leone - Quality Essential Health Services and Systems Support Project	Parent Project ID (if any)
Region AFRICA WEST	Estimated Appraisal Date 18-Oct-2021	Estimated Board Date 09-Dec-2021	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Ministry of Finance	Implementing Agency Dr. Francis Smart, Partners in Health (PIH)	

Proposed Development Objective(s)

The PDO is to increase utilization and improve quality of maternal and child health services in the selected areas.

Components

- Component 1: Improving quality, efficiency, and effectiveness of Reproductive, Maternal, Newborn, Child and Health and Nutrition services
- Component 2: Strengthening National Level Systems
- Component 3: Project Management and Monitoring and Evaluation
- Component 4: Contingent Emergency Response project (CERC)

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	60.00
Total Financing	60.00
of which IBRD/IDA	40.00
Financing Gap	0.00

DETAILS

World Bank Group Financing



International Development Association (IDA)	40.00
IDA Grant	40.00

Non-World Bank Group Financing

Trust Funds	20.00
Global Financing Facility	20.00

Environmental and Social Risk Classification

High

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. Sierra Leone has recorded solid economic growth since the end of the Ebola epidemic in 2016.

Before the COVID-19 pandemic, gross domestic product (GDP) growth was projected to reach 5.4 percent in 2019—the highest growth since 2016. Sierra Leone’s fiscal deficit had declined from 5.7 percent of GDP in 2018 to 2.9 percent in 2019. The fiscal stance was generally contractionary, with a wide range of measures to raise domestic revenue and rationalize expenditures. However, due to an expected expansionary fiscal outlook to address the impact of COVID-19, the budget deficit was expected to increase from 2.9 percent of GDP in 2019 to 8.9 percent in 2020. The pandemic has generated debt vulnerabilities as public debt increased by 7.3 percentage points relative to the pre-COVID-19 debt forecast, reaching 76.6 percent of GDP in 2020. The current account balance decreased from 18.7 percent in 2018 to 14.0 percent in 2019. Annual average inflation rate has been trending down, from 16.0 percent in 2018 to 14.8 percent in 2019.

2. Economic performance has been undermined by the COVID-19 pandemic, which has eroded the country’s fiscal gains.

The government’s commitment to preserving fiscal and macroeconomic stability has been put on hold since the onset of the pandemic in March 2020. The pandemic has led to a dramatic fall of tax revenues, making it difficult for the government to mitigate the fiscal pressures from increased spending, including on health. As a result of the fiscal pressures, the government submitted a supplementary budget of US\$170 million to Parliament in July 2020 with the theme “Saving Lives and Livelihoods” to support the COVID-19 response. On the revenue side, the tax capacity has been set back by the COVID-19-related economic contraction, especially in the services sector. As a result, in the supplementary budget, total expenditure increased by 2.8 percent of GDP, whereas domestic revenue declined by 2.6 percent of GDP. These factors have constrained poverty reduction, with 56.8 percent of Sierra Leone’s population still living below the poverty line.



3. **Sierra Leone continues to face significant human development challenges amid several crises including the COVID-19 pandemic and climate change.** The country ranks 182nd out of 189 countries on the 2019 United Nation’s Human Development Index (HDI), with an HDI of 0.452 – lower than the sub-Saharan Africa (SSA) average (0.547). Sierra Leone scores 0.36 on the 2020 World Bank Human Capital Index (HCI), indicating that a child born in Sierra Leone today will only achieve 36.0 percent of his/her productive potential if key health and education outcomes remain the same. Moreover, according to the Notre Dame Global Adaptation Initiative (ND-GAIN), Sierra Leone is the 17th most vulnerable country to climate change and the 50th least **ready** country to adapt to climate change in the world.¹

Sectoral and Institutional Context

4. **While Sierra Leone has made progress on some key health indicators, health outcomes show mixed results.** Health outcomes have seen improvement overall, but a comparison with peer countries shows equal or slightly worse trends. Between 1990 and 2017, life expectancy at birth increased from 39 years to 54 years but remains the fourth lowest globally. The country’s health status metrics on maternal and child health and nutrition are lower than low-income countries (LICs), as well as regional and subregional averages (Table 1). While Sierra Leone’s level of public health expenditures is about the same as that of comparator countries, it has one of the highest maternal mortality ratios (MMRs) in the world, at 717 maternal deaths per 100,000 live births. High risk of maternal death is found to be associated with a high prevalence of teenage pregnancy. Forty-seven percent of maternal deaths among women ages 15–19 years old occur due to complications during pregnancy or childbirth as well as unsafe abortions. Adolescent pregnancy is also closely related to high child mortality. The country recorded an under-five mortality rate of 122 per 1,000 live births, an infant mortality rate of 75 per 1,000 live births, and a neonatal mortality rate of 31 per 1,000 live births (SLDHS 2019). The mortality rate among children under five years old whose mothers are less than 20 years old is 1.2 times higher than those whose mothers are 20 years or older. Further, malaria has been the leading cause of death among the population, with 8,324 disability-adjusted life years (DALY). Once infected, pregnant women risk anemia, premature delivery, and stillbirth. Although the stunting rate for children under-five has declined per the recently published Sierra Leone Multiple Indicator Cluster Survey (MICS), it remains high at 26.4 percent² (Statistics Sierra Leone 2018).

Table 1: Mortality and Stunting Rates in Sierra Leone relative to Averages in Low Income Countries, West Africa, and Sub-Saharan Africa

Indicator	Sierra Leone	West Africa Sub-region Average	Sub-Saharan Africa Average	Low Income Countries (LIC) Average
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¹University of Notre Dame. 2019.Sierra Leone ND-GAIN profile and index ranking. Retrieved at: <https://gain-new.crc.nd.edu/country/sierra-leone>

² Sierra Leone Multiple Indicator Cluster Survey (MICS), 2017



Neonatal mortality per 1,000 live births	20 ^a	28	28	26
Infant mortality per 1,000 live births	56 ^a	52	53	48
Under-five mortality per 1,000 live births	94 ^a	76	68	78
Maternal mortality ratio (MMR) maternal deaths per 100,000 births (modeled estimate)	717 ^a	535	534	462
Stunting (low height for age) % children under five	26.4 ^b	–	34.1	35.2

*SLDHS 2019; **SLDHS 2019; SLMICS 2017 ***

5. **The health care delivery system in Sierra Leone is coordinated centrally by the Ministry of Health and Sanitation (MoHS).** The MoHS is responsible for the regulation, resource mobilization, provision of health services and quality assurance, health research, policy formulation and implementation, and staff capacity building. The District Health Management Teams (DHMTs) manage, monitor, and oversee the health care service delivery and provision of disease prevention, health promotion, health education, and safe water and environmental sanitation, at the district level across the country. Most of the health facilities in Sierra Leone are public.

6. **Sierra Leone's public health service delivery system is organized in three tiers of service delivery.** The three tiers are primary health care, secondary health care, and tertiary health care. Primary health care services are mainly delivered at the Peripheral Health Units (PHUs). The PHUs are categorized in a hierarchy based on the clinical skills of the personnel and the infrastructural availability. These categories include maternal and Child Health Posts (MCHP), Community Health Posts (CHP), and Community Health Centers (CHCs). Secondary health care is delivered in the district hospitals. These hospitals handle referrals from PHUs and accept walk-in patients who live in the surrounding communities. Tertiary health care is delivered by more advanced and specialized regional hospitals as well as hospitals located in the capital, Freetown. They are mainly the teaching hospitals.

7. **Health care financing sources are mainly households, development partners, government, and households.** The government's share of health expenditures is small compared with the other two sources. In 2018, the government's share of all the three sources combined was about 10 percent (9.71 percent), which was small compared with the other two sources. Development partners (DPs) support represents over a quarter (25.88 percent). Household out-of-pocket (OOP) payments (excluding prepaid private spending) makes up nearly 45 percent (44.78 percent). Seventy percent of such household expenditures go into drugs, where there are structural inefficiencies due to irrational prescription and sale of counterfeit drugs. About 10 percent of the population faces the risk of catastrophic spending on health (DPPI, 2020).

8. **The relatively poor health outcomes as noted above are, in part, the results of poor quality and**



inefficient service delivery. While there has been some progress, more can be done to improve the quality-of-service delivery. A key bottleneck to improving quality of care is the availability and caliber of skilled core health workers. In Sierra Leone, the skilled health worker density is only 6.40 per 10,000 (23 per 10,000 is recommended by WHO) population, while physician density is estimated at 0.05 per 1,000 population across the country³. Health care providers can correctly diagnose less than half (44.6 percent) of five tracer conditions.⁴ Sixty-seven percent of doctors can correctly diagnose all the tracer conditions compared with Community Health Officers-CHO (59.7 percent), and nurses (44.5 percent). There is significant variation between provider knowledge and practice gap with huge differences between diagnosis and treatment across facilities. For example, while 97 percent of doctors can correctly diagnose pulmonary tuberculosis, only 5 percent can provide correct treatment. Health care providers in hospitals correctly diagnose 61.7 percent tracer conditions, followed by health centers (49.4 percent) and health posts (46.3 percent). Quality is better in urban areas than rural areas with diagnostic accuracy higher in urban facilities (50.9 percent of clinical cases are diagnosed correctly) than rural facilities (37.3 percent). Quality of care is also affected by large number of volunteers who form substantial proportion (about 40%) of frontline health workers. Sierra Leone has an average maternity bed availability of 8 per 1,000 pregnant women (10 per 1,000 pregnant women is recommended by WHO). Only 4.8 percent of PHC facilities have the resources to provide Basic Emergency Obstetric and Neonatal Care (BEmONC). Drug availability, particularly for mothers and children is quite poor with only 56 percent of essential drugs available in most health facilities. The availability of medical equipment is also higher in urban areas (40.0 percent of facilities) than rural areas (28.3 percent), which is below the national average of 31.9 percent. These issues underscore the need to improve quality of essential health services to increase utilization of health services and improve the health status of the population.

9. **Although some progress has been made in the implementation of Health Management Information System (HMIS), more needs to be done to improve its functionality.** Currently, most health facilities are constrained with making HMIS more effective in supporting routine health service delivery. The constraints include lack of requisite human resources, lack of information and communication technology (ICT) equipment, unreliable internet connectivity, and poor power supply. Public facilities rely primarily on paper-based data collection systems, while private sector data are not regularly collected by MoHS. There is little government investment in the HMIS, which leads to inadequate capacity for data management at the central, DHMT and health facility levels. Data use and feedback from the central MoHS to DHMTs and from DHMTs to PHUs remain poor. (NHSSP 2016-2020).

10. **Managing medical waste to ensure service delivery happens in a congenial atmosphere that minimizes health care related infections is a major problem across all health facilities in the country.** Almost all health facilities, including Connaught Hospital practice open burning. Besides, incinerators installed in most hospitals and other health facilities have high running costs as they are properly designed, sized, and optimized. As a result, they generate harmful pollution posing a risk to human health in nearby communities. It is important to revamp waste management systems and ensure that better waste disposal practices become part of the routine service delivery at all levels of the health care delivery

³ Sierra Leone has a workforce of 4,826 skilled health workers: 323 physicians, 389 Community Health Officers, 3,185 nurses, 402 midwives, 41 pharmacists, 30 nutritionists and 456 laboratory technicians. (SARA,2017).

⁴ Tracer conditions include malaria with anemia, diarrhea with severe dehydration, pneumonia, pulmonary tuberculosis and diabetes (SDI 2018 and 2021).



system.

11. **Weaknesses in governance and leadership systems are widespread across the health sector, particularly at the district level.** Systems required to govern and ensure that service delivery units and institutions have been resourced are weak. Financial management, procurement, internal audit, human resource management, and administrative systems at health facility and DHMT level are still poor, inefficient. The situation is more pronounced at the district level where a significant number of health facilities and DHMTs have low capacity in planning and implementing activities as well as performing fiduciary functions. Most facilities and DHMTs do not have the personnel who are able to support preparation and execution of health budgets, including donor funds. The inadequate governance and leadership systems often lead to delays in the implementation of activities and supply of health care products to health facilities, which deprive Sierra Leoneans of the opportunity to benefit from timely delivery of quality health services at the primary health care level.

12. **Public schools in Sierra Leone lack basic school health services.** Having recognized the importance of improving learning outcomes of school health services, the Government of Sierra Leone (GoSL) has developed a school health policy that seeks to improve the health of school-age children. The overall objective of the policy is to create a healthy school environment for learning that is free from disease. However, many basic and secondary schools across the country lack school health services. The quality of the existing Adolescent and Youth Friendly Clinics (AYFC) varies greatly due to lack of resources, including staffing and training. The recurring theme, however, is the weak coordination across actors, leading to duplication of services in the urban areas while those in remote areas are underserved. Most of school interventions are project-based, limited in geographical scope, and services are not being provided to many students, particularly in rural areas⁵.

13. **While some measures have been taken by the GoSL to address gender-based violence, gaps remain in the availability of critical services for survivors, including health care and psychosocial support.** Forms of GBV include domestic violence, sexual assault, including rape of adults and minors, rape in marriage and school-related sexual abuse, as well as harmful practices such as female genital mutilation (FGM). MoHS is mandated to provide free medical examination and treatment and referrals for other essential services, including clinical care and psychosocial support for gender-based violence (GBV) survivors, but these services are not widely available. Currently, GBV-specialized health services are available in 10 out of the 16 districts. However, survivors are still underserved due to insufficient capacity at the health facility level. It is expected that the GBV services provided as part of this project would complement others not only to raise awareness but to prevent GBV, which in some cases can result in unwanted pregnancies, reproductive health complications and even death of women and girls.

14. **The project will support some of the objectives set out by GoSL in its medium-term National Development Plan (NDP) (2019–2023) to address the country's health sector challenges.** Those objectives will include the following: (a) improving health systems governance and human resource management; (b) improving primary and secondary health care delivery systems; (c) strengthening the Health Management and Information System (HMIS) through digitalization of health care systems and

⁵ Government of Sierra Leone School Health Policy, 2020.



processes; (d) encouraging public-private partnerships (PPP) by developing the policy and legal framework to pave way for private investments in health (e) promoting efficient health-care delivery; and (f) reintroducing school health services in secondary schools.

15. **The World Bank has assisted Sierra Leone’s health sector in various projects.** Through the Ebola Emergency Response Project (EERP), the World Bank contributed to controlling outbreaks of the Ebola virus disease and the recovery of selected essential health services. The EERP also supported the establishment of the National Emergency Medical Service (NEMS), which now manages a network of 81 ambulances across the country. The EERP also helped the professional development of medical personnel, although more can be done to meet the growing health care needs of the country. Through the Health Services Delivery and Systems Support Project (HSDSSP), the World Bank assisted the national Community Health Worker (CHW) program, supporting the provision of technical assistance to improve program management and payment of incentives; construction of a state-of-the-art health facility in Kailahun District; and human resource development with a focus on training medical students at the School of Clinical Sciences (SCS) in Makeni. The World Bank also supported the health sector through the Regional Disease Surveillance Systems Enhancement (REDISSE) Project, which assists in strengthening the country’s laboratory system for improved testing capacity as well as the disease surveillance system. REDISSE also enhanced the operational capacity of the National Emergency Operation Center (EOC) and cross-border collaboration to exchange information. More recently, the World Bank, through the COVID-19 Emergency Preparedness and Response Project (CEPRP), has supported Sierra Leone in making improvements to electronic data reporting and availability of laboratory results within 72 hours. CEPRP has boosted the capacity of laboratory personnel to diagnose COVID-19 cases and made updates to the 117-call alert system.

16. **The proposed project is designed to provide additional support to the MoHS as it continues to improve its health services.** There is a need to build on past projects, which strengthened disease prevention, service delivery, and pandemic preparedness and response, through an integrated approach at the district level. The proposed project will support development of a hub-and-spoke organization design at the district level to deliver health services, particularly for women and children (Box 1). This innovative approach to improving quality essential health services will be implemented through a public-private partnership (PPP). With support of the World Bank, the GoSL intends to deploy a partnership between the MoHS and Partners in Health (PIH) to implement the proposed activities. PIH is a reputable US-headquartered international public health not-for-profit organization, which collaborates with developing country governments to strengthen health systems to deliver quality health care services. PIH has experience in designing and executing district-focused, primary health care services in Lesotho, Rwanda, and Sierra Leone.

Box1. Hub-and-Spoke Model Defined

Hub-and-spoke organization design is a model which arranges service delivery assets into a network consisting of an anchor health facility (hub) which offers a range of services, complemented by lower-level facilities (spokes) which offer limited services, referring patients, who require more intensive services to the hub for treatment.

Basic healthcare services are broadly distributed across the network, permitting the bulk of healthcare needs of the target population to be addressed locally. Only when complexities emerge that require care falling outside of the scope of services provided at satellite facilities are patients referred to the



hub for treatment.

Source: Elrod, J. K. and Fortenberry Jr., J. L (2017). The hub-and-spoke organization design: an avenue for serving patients well. BMC Health Services Research 2017, 17(Suppl 1):457.

17. **In Sierra Leone, PIH has collaborated with MoHS to deliver improved health services in Kono District.** Basic emergency obstetric neonatal care (BEmONC) coverage in Kono District increased from 20.0 percent in 2017 to 39.9 percent in 2020. The Cesarean section coverage rate doubled from 2 percent in 2017 to 4.2 percent in 2020. Regarding quality of care, the decision-to-incision time for obstetric complications decreased by 69.0 percent. Maternal health-related referrals from Wellbody Clinic to Koidu Government Hospital resulted in a 93.0 percent recovery rate (149 out of 161) in 2018. Other outcomes achieved through the MoHS–PIH partnership in Kono District include only one maternal death at the main PIH Wellbody Clinic between 2016 and 2020; a low mortality rate of 1 percent for children under five years old who tested positive and received treatment for malaria; and a 75 percent reduction in the stillbirth rate between 2018 and 2020. Refer to annex 3 for information on the PIH programs in Lesotho and Rwanda.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

18. The PDO is to increase utilization and improve quality of reproductive, maternal, child health and nutrition services in selected areas.

PDO Level Indicators

- a. People who have received essential health, nutrition, and population (HNP) services (children immunized + nutrition services + deliveries by a skilled birth attendant) in target districts (Number).
- b. Pregnant women who attended antenatal care (ANC) four or more times by skilled health personnel in target districts (number).
- c. Births attended by skilled health personnel in target districts (number).
- d. Average Score of Health Facility Quality of Care⁶ in the target facilities (Percentage).

⁶ The composite score includes the availability of all priority drugs, essential equipment, diagnostic tests, and the existence of minimum level of clinical staff, according to staffing norms.



D. Project Description

19. **The proposed project will consist of four components which are described below.** Through these components, the project will prepare the MoHS to implement the hub-and-spoke services delivery model to improve quality essential health services. The approach will be supported by targeted implementation of digital health systems to improve efficiency of service delivery. The project will also address the challenges posed by COVID-19 by establishing a link between public health emergency response and essential health services.

Component 1: Improving quality, efficiency, and effectiveness of Reproductive, Maternal, Newborn, Child and Health and Nutrition services (Estimated US\$31.50 million: IDA US\$20.50 million; GFF CG US\$4.00 million; GFF EHS US\$7.00)

20. **Proposed activities under this component will support the delivery of quality essential health services** in Bonthe, Falaba, Kailahun, Tonkolili, and Western Rural Districts. This component will be jointly financed by IDA, GFF country grant and GFF Essential Health Services Grant (EHS). It will finance an assessment to determine staffing, supply and equipment, infrastructure of health facilities designated as hubs and spokes. It will support facility-level management information systems by providing consultant services to develop integrated clinical processes, data registry, digital forms and other documentation, and digital patient files to inform clinical decision-making as essential parts of electronic medical records (EMR). The component will also finance the recruitment, training and coaching/mentoring of health professionals, administrative and operational personnel, including training staff on preventing and taking care of climate-related health risks. The component will make available medicines, laboratory supplies and equipment, consumables, as well as cleaning and infection prevention and control materials. The component will also finance climate-smart rehabilitation and/or construction of selected health facilities and provision of climate-sensitive medical equipment, constant water, and electricity supply, including solar energy. It will support facility operations and routine maintenance to ensure smooth functioning of the facilities as well as climate adaptation measures to minimize negative climate-related health impacts on patients.

21. Community Health Centers (CHCs) will be the hubs, each of which will be networked with about 20 Maternal and Child Health Post (MCHPs) and Child Health Posts (CHPs) (spokes). Services they are expected to offer include basic emergency obstetric and neonatal care (BEmONC), basic Reproductive, Maternal, Newborn, Child, and Health (RMNCH) services, treatment of severe childhood illnesses, laboratory and pharmacy services, screening, and referral for non-communicable diseases (NCDs), and surveillance and response to epidemic disease outbreaks. The spokes are expected to provide antenatal care (ANC), postnatal and neonatal care, growth monitoring, basic first aid, routine vaccinations, nutrition services and products, promotion of breastfeeding, thermal care, and hygiene practices. The spokes will refer institutional deliveries, and critical under-five and RMNCH cases to the hubs. The referral system will therefore be strengthened. This will involve improved communication structures including a closed user



group, which will connect the hubs and the spokes. In addition, patients will be helped with referral scheduling and transportation from the spokes to hubs using the existing ambulance services operated under the National Emergency Management System (NEMS). The hubs will refer critical U5 and RMNCH cases, as well as those requiring specialized care to the district hospitals. The referral systems from hubs to hospitals will be mapped for each target facility and will build on existing NEMS and DHMT structures, with targeted time-limited equipment, maintenance, communication materials, and HR support to make existing systems functioning, based on a structured PIH-led assessment. Providers in hubs will be trained on correct use of existing protocols and standard operating procedures (SOPs) to ensure referrals happen for the right conditions, including high risk pregnancies, management of medical and surgical emergencies, major surgical interventions, inpatient care, laboratory testing, and medical imaging. Monthly coordination calls will be set up between hubs and hospitals to troubleshoot system-level issues.

22. Nutritional support will be an integral part of the routine services provided by the designated facilities. Nutritional services will be provided to the target beneficiaries, comprising infants, children under 5, pregnant and lactating mothers, and other vulnerable adults, meeting defined clinical criteria. Children under 5 would be screened as part of routine services, with targeted referrals from communities by CHWs, and offered one of two packages depending on clear indicators, including Body Mass Index (BMI) and Mid-Upper Arm Circumference (MUAC). Those diagnosed with severe acute malnutrition (SAM) would receive time-limited support with ready-to-use therapeutic foods (RUTF), provided to their parent/caregiver after clinic visits, until measurable improvements in indicators can be observed. Children with moderate acute malnutrition (MAM) would be supported through provision of locally available, affordable, nutrient- and protein-rich foods, including benni mix, a food consisting of locally grown beans mixed with rice and additional protein. All other caregivers with children not diagnosed with acute malnutrition will receive age-appropriate infant and young child nutrition counseling. For efficiency and sustainability, mothers and caregivers would be given bulk commodities and taught preparation methods until children no longer need additional support, as determined in subsequent clinic visits. Additional nutritional support would be provided to limited numbers of adults where there is a clear clinical need based on evidence, with a focus on pregnant women showing signs of poor nutrition during their first ANC visit. Other eligible adults might include newly diagnosed malnourished TB patients undergoing treatment. In all cases, nutrition support will be integrated into clinic flows and programming overseen by trained nurses. There will be community outreaches to women of childbearing age, especially teaching them on how to prepare highly nutritious food for their children. The existing mother support groups (MSGs) will lead this activity in the communities.

23. Each hub is expected to supervise and serve as a training center for the spokes in its network. Hub administrators will provide monthly outreach visits with clinical, operational, and monitoring and evaluation (M&E) specialists to enhance clinical quality and management, data reporting and referral algorithms at the spokes. The hub administrators will routinely report to the District Medical Officer (DMO) of the DHMT, who will be responsible for oversight. Staff at hubs will receive a one-month refresher training on the basic package of emergency obstetric and neonatal care, M&E, quality improvement and general medicine, followed by weekly mentorship by district-based supervisory staff. Maternal health mentorship will be adapted from an existing mentorship model piloted in Kono District, which focuses on ensuring all mothers have partographs charted, clinicians can correctly start and interpret the partograph, and can identify emergencies through the Maternal Early Obstetric Warning Signs (MEOWS) and make referrals as appropriate. A simplified training package to improve newborn



survival will focus on early initiation of breastfeeding, thermal care, and hygiene practices. Community Health Workers (CHWs), who will be trained to screen and refer common illnesses, will carry out community-based sensitization activities to drive increases in visits by children under five years of age and ANC visits and facility-based deliveries. Quality improvement activities will also be undertaken to further promote service utilization. Quality of care will be improved through upgrading operational processes, including maintenance systems, information systems and clinical protocols using existing tools developed by MoHS. Providers will be trained to ensure that services are youth-friendly and promote sexual and reproductive health.

24. The component will strengthen health systems in Bonthe, Falaba, Kailahun, Tonkolili, and Western Rural Districts to improve primary healthcare service delivery. This will include establishing an integrated governance and public financial management (PFM) system with adequate staffing and resources at the DHMT and building capacity of DHMT staff. Technical support will be provided in areas such as financial management and planning, supply chain, public health, and data management. Day-to-day support will be combined with formalized teaching, including through an online learning community, a cross-district learning collaborative, and in-person training in key public health management skills. Learning materials will be customized using a mixture of existing courses from Kono District and materials adapted from PIH-led health system improvement projects in Rwanda and Lesotho. The component will also upgrade the M&E system by reviewing and updating data collection forms, the M&E manual, indicator protocols, and reporting tools. The project will also support the digitalization of Health Management Information Systems (HMIS), which will entail providing technical assistance for assessing the existing systems, providing digital tools, training of data entry clerks, and working with M&E officers to strengthen their capacity to use the systems. Support will also be given to strengthen CHW operational capacity by exploring the possibility of working with NGOs with track records of good quality CHW to run the district CHW program, as well as financing regular supportive supervision, provision of supplies and tools, and rewards to increase retention and boost performance of CHWs.

25. The project will also cover health facility water quality, school health and GBV- support services. Specific areas of focus will include building the capacity of environmental health and sanitation workers to improve health facility water quality at the point of use. This will entail reviewing and updating of water, sanitation, and health (WASH) standard operation procedures, protocols, and guidelines in designated health facilities Bonthe, Falaba, Kailahun, Tonkolili, and Western Rural Districts. The project will also procure water quality testing kits to ensure safe drinking water at the designated health facilities and supply first aid kits to selected schools in Bonthe, Falaba, Kailahun, Tonkolili, and Western Rural Districts. Teachers will be trained in basic health care skills to allow them to treat first aid cases that occur in schools, while referring serious cases to health facilities for treatment. The project will provide support services for survivors of GBV. GBV services will be integrated into health care delivery in the designated health facilities. The project will support training activities to familiarize health workers with a GBV training manual (developed with support of the World Bank) to develop relevant skills to provide services to GBV survivors.



Component 2: Strengthening National Level Systems (Estimated US\$20.50 million: IDA US\$13.50 million; GFF CG US\$4.00 million; GFF EHS US\$3.00)

Subcomponent 2.1: Strengthening leadership and HRH capacity, PFM, pharmaceutical supply chain systems, and private sector participation (Estimated US\$12.50 million: IDA US\$7.50 million; GFF CGUS\$2.00 million; GFF ESH US\$3.00)

26. **Proposed activities under this subcomponent aim to strengthen leadership and clinical and nonclinical capacities to effectively drive the health care delivery agenda of the country.** This subcomponent will support refresher courses in public financial management, public health, and health economics for senior management at MoHS to improve planning, ensure effective implementation of policies, and enforce accountability and fiduciary measures. It will also support operational costs (e.g., communications, mobility, supervision, logistics etc.) of the newly established MoHS delivery team and provide technical assistance aimed at developing the curriculum and setting up a unit at a tertiary educational institution to train health economists and health financing specialists. The subcomponent will also strengthen academic staffing, review curriculum, and establish a formal affiliation between the University of Sierra Leone and the Makeni School of Clinical Sciences (SCS). There will also be support for curriculum development for the College of Medicine and Allied Health Sciences (COMAHS), including the Dentistry Department and Public Health Department and Midwifery School. Assistance will be provided to a training program aimed at upgrading the skills of State Enrolled Community Health Nurses (SECHNs) to enable them to transition to becoming midwives and state registered nurses (SRNs). The subcomponent will also help finance GoSL's efforts to expand an ongoing training of general surgery students, including ensuring full accreditation for postgraduate training in pediatrics, obstetrics, and gynecology.

27. **The project will support the establishment of a unified financial management and reporting portal to align donor expenditures with the government system within the overall PFM architecture of the country.** A similar portal has been successfully set up in Bangladesh with World Bank support. The objective is to build accountable institutions that respond to the needs of citizens and ensure that funds are used for their intended purposes. The system, which will be linked to MoHS and the Accountant General's Department, will be designed to improve the use of country systems by minimizing manual paper-based processes and synchronizing fragmented parallel fiduciary systems, addressing delays in reporting, and weak financial records management. The project will support the institutionalization of resource monitoring and expenditure tracking (RMET) at MoHS. It will also finance a study to assess the possibility of digitalizing the revenue and accounting systems in Connaught Hospital and a district hospital. The main goal of this study is to improve revenue and expenditure management at the health facility level. Findings of the assessment will inform the piloting of digitalized revenue and accounting systems at the two hospitals. The project will finance technical assistance to support establishment of a public-private partnership (PPP) unit at MoHS.

28. **In collaboration with the World Bank Governance Global Practice,** the project will support MoHS to strengthen supply chain systems at the National Medical Supplies Agency (NMSA). Inventory management software will be procured to improve the operational efficiency of NMSA. This activity will



be financed under the World Bank Accountable Governance for Basic Service Delivery (P172492) project as part of the Health, Nutrition and Population (HNP) and Governance GP collaboration. Innovative digital and offline data platforms that work with and improve existing data management information system at NMSA will be designed and rolled out. While the Governance project will finance the software and digital platform, this project will finance technical assistance to develop NMSA's strategic and operational plans.

Subcomponent 2.2: Strengthening epidemic preparedness, understanding non-communicable disease risks, and managing medical waste (Estimated US\$8.0 million: IDA US\$6.0 million; GFF CG US\$2.00)

29. **The cumulative effects of crises relating to Ebola, the COVID-19 pandemic and climate change have underscored the need to further strengthen systems to prevent, detect and respond to infectious disease outbreaks.** To sustain GoSL's emergency preparedness and response efforts, this project will support selected national systems by transitioning the national EOC to a viable National Public Health Agency (NPHA) by developing standard operating procedures and building the capacity of existing staff to improve its operational efficiency. The project will strengthen the 117-call alert system by upgrading its software and covering a portion of its operating costs and upgrade the country's main points of entry by supporting minor rehabilitation works, including equipping the Jendema crossing point to allow for effective delivery of cross-border services during epidemics. It will also improve human resources for animal health by supporting the training of 16 para-veterinary officers in collaboration with the Ministry of Agriculture and Forestry (MAF). In addition, the project will finance development of a new para-veterinary training curriculum at a designated tertiary education institution.

30. **The project will collaborate with other ongoing COVID-19 project (parent and AF) and REDISSE,** particularly in risk communication to reduce COVID-19 vaccines hesitancy. It will strengthen the linkage between Risk communication at national, district, community level. At the community level, the CHWs will be at the forefront of the implementation of the risk communication activities. They will work closely with the DHMTs to sensitize communities about the need to be fully vaccinated.

31. **The project will contribute to efforts to understand NCD risks.** With the support from the World Bank, a national NCD policy and strategy have been developed. To help implement the strategy, the project will support a WHO STEPwise Approach to Surveillance of Noncommunicable Diseases (STEPS) survey to provide evidence and data for NCD risk factors. The last STEPS survey was conducted in 2009. At the same time, the project will support the development of guidelines for managing NCDs at the health facility level.

32. **The project will also pilot an eco-friendly Centralized Medical Waste Management Facility (CMWMF) in Western Urban and Western Rural districts in the Freetown area.** The project will finance the establishment of a medical waste center and the procurement of medical waste management machines, refrigerator trucks, and recurrent costs of hiring a facility administrator. Facility operations and maintenance manual that would guide the operation of the facility will be developed. The establishment of this facility will be informed by the Sierra Leone Climate and Health Vulnerability Assessments (CHVA) to ensure the implementation of this activity takes account of climate related flooding risks and projected changes in sea level. The government is exploring several options in terms of CMWMF technologies, and



the possible location of the facility based on the result of an initial assessment of the expected quantity of medical waste in the target areas, potential sites, and technology options. A feasibility study to determine type of technology, the prevailing baseline conditions, risk levels associated with the locations, and management and handling of the CMWMF will be conducted.

Component 3: Project Management and Monitoring and Evaluation (Estimated US\$8.00 million: IDA US\$6.00; GFF CG US\$2.00 million)

Subcomponent 3.1: Project management (Estimated US\$ 5.00 million: IDA US\$4.00 million; GFF CG US\$1.00)

33. **The Directorate of Policy Planning and Information (DPPI) of MoHS will be the coordinating unit of the project, providing technical oversight of project implementation.** Led by the Director of DPPI, the unit will ensure that the implementing partners execute their planned activities and submit reports to the Integrated Health Project Administration Unit (IHPAU) on time. IHPAU will manage day-to-day operations of the project. It will focus primarily on managing the fiduciary (financial management and procurement), M&E, and environment and social aspects of the project. A team of MoHS and IHPAU staff will jointly supervise and monitor implementation of project activities periodically. IHPAU will be responsible for producing quarterly implementation progress and annual audit reports. This subcomponent will strengthen the capacity of IHPAU staff through a combination of on-the-job training, technical assistance, operational clinics, and targeted short courses. It will also finance all the IHPAU's staff costs, including technical assistance to strengthen the capacity of procurement, finance, M&E, and safeguards units.

Subcomponent 3.2: Strengthening monitoring and evaluation and knowledge management (Estimated US\$3.00: IDA US\$2.00 million; GFF CG US\$1.00 million)

34. **The project will support activities to build the M&E capacity of DPPI, IHPAU and DHMTs to improve data collection and analysis at the central, district, and facility levels.** The capacity of M&E staff at the central MoHS, IHPAU, and district level will be strengthened to improve data quality in terms of completeness, accuracy, consistency, and timeliness. This will be done through a recruitment of a technical assistance to provide hands-on-the job training for the M&E staff. The aim is to strengthen existing M&E systems for the key stakeholders such as DPPI, IHPAU, DHMTs, and so forth. Levels of project M&E implementation will include results framework monitoring, activity implementation and financial monitoring, implementation support missions, midterm review and preparation of implementation completion reports (ICRs), and monitoring of training and capacity building. Data collection and reporting will include data generation and analysis and beneficiary/impact assessment (baseline, midline and endline). To adequately inform decision-making, strong M&E utilization activities will be carried out during implementation. Finally, this subcomponent will support knowledge management by documenting and disseminating project achievements and lessons learned. It will support DPPI's activities to conduct analyses, promote data use to improve policy and decision-making, and supervise and assure data quality. DPPI's capacity will be developed to produce dissemination materials such as briefs, reports, posters,



flyers, stories, videos, infographics, and messaging for various communication channels, including social media platforms, to widely share project results.

Component 5: Contingent Emergency Response project (CERC)US\$0

35. In accordance with OP/BP 10.00 (Investment Project Financing), paragraphs 12 and 13, a contingent emergency response component is required. Therefore, this component will respond to an eligible crisis or emergency, as needed. It will allow the Government to request the World Bank for rapid reallocation of project funds to respond promptly and effectively to an eligible emergency or crisis that is a natural or artificial disaster or crisis that has caused or is likely to imminently cause a major adverse economic and/or social impact. If the World Bank agrees with the determination of the disaster and associated response needs, this component will draw resources from the categories financing other components and/or allow the Government to request the World Bank to recategorize and reallocate financing from other project components to cover emergency response and recovery costs. This component could also be used to channel additional funds should they become available because of an emergency. Disbursements will be made against a positive list of critical goods or the procurement of works and consultant services required to support the immediate response and recovery needs. The funds should be reallocated to achieve the key indicators in the Results Framework.

Legal Operational Policies	
	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

36. **The project E&S footprint is generally localized, but the risk could be highly significant, especially with the inclusion of a medical waste management aspect.** The project will be processed under the environmental and social framework (ESF) and is therefore guided by the relevant environmental and social standards (ESSs). There are risks associated with occupational health and safety (ESS2) of contractor workers; air and water pollution or contamination from project physical activities with specific reference to medical waste management, and unwise selection and sourcing of construction materials, inefficient use of water and energy (ESS3), community health and safety as it relates to traffic and accidents, transmission of infections focusing especially on COVID-19, and issues related to pollution (ESS4), potential land acquisition for the construction of water supply and sanitation facilities and construction and rehabilitation of the existing district hospitals (ESS5), impact on ecosystems and wetlands and biodiversity as a result of project externalities, especially if civil works are conducted in the wet season (ESS6). These risks can be managed by the preparation and implementation of appropriate E&S safeguards instruments (ESS1), and by the empowerment of the client through capacity building and training to monitor and supervise the implementation of the project.



E. Implementation

Institutional and Implementation Arrangements

Institutional Arrangements

Ministry of Health and Sanitation (MOHS)

37. **The project will be coordinated by the Director of the DPPI at the MoHS.** As the project coordinator, the DPPI director will work under the leadership of the Chief Medical Officer (CMO) to inform MoHS about implementation progress. The DPPI director will be responsible for all communications, including policy dialogue with the World Bank, liaising with the World Bank's Task Team Leader (TTL) on all project related matters.

Project Steering Committee (PSC)

38. **The project will use the existing PSC under MOHS.** It is composed of the Ministry of Finance, Ministry of Health and Sanitation, Ministry of Agriculture and Forestry, Ministry of Basic Education, Ministry of Higher Education, Ministry of Energy, Ministry of Local Government and Rural Development, Head of the Environment Protection Agency, Ministry of Development and Economic Planning, Ministry of Gender and Children's Protection, and nonstate actors. The main function of the PSC is to provide oversight for project implementation. The committee will meet quarterly to review implementation progress and ensure that the project stays on course.

District Councils (DCs)

39. **DCs are the highest political entity at the district level. They are responsible for providing oversight in terms of the implementation of the GoSL's health strategy at the district level.** They will be major stakeholders in the implementation of the project activities, particularly in fiduciary management. In collaboration with the Governance GP colleagues, the DC's fiduciary capacity will be strengthened to allow them to support the DHMTs in planning, budgeting and expenditure management.

Implementation Arrangements

Central Level

40. **The DPPI director, as the project coordinator, will be responsible for supervising project's implementing partners.** The director will oversee the day-to-day implementation of project activities. As the project coordinator, the director will work closely with other implementing partners at the national



and district levels as well as report on project implementation progress to the Minister of Health and Sanitation. The DPPI director will also be responsible for project-related communications, including policy dialogue with the World Bank.

41. **The IHPAU manages donor-funded health projects on behalf of MoHS.** The five major donors include GF, GAVI, Islamic Development Bank (ISDB), US Centers for Disease Control and Prevention (CDC), and the World Bank. Each donor has its dedicated staff who work exclusively on the respective donor project. Linking the dedicated staff and the donors is the Team Lead (TL) who coordinates, provides oversight and undertake management of IHPAU. The World Bank's dedicated staff consists of five teams headed by a finance specialist, a procurement specialist, an M&E specialist, a senior internal auditor, and a safeguards specialist. Each specialist manages their respective teams and reports to the TL. The TL reports to the Director of DPPI who the interlocutor between MoHS and the World Bank is, communicating all project related issues to the World Bank's TTL on regular basis. The TL provides weekly updates of project implementation to the MoHS Executive Management Committee (EMC), which is headed by the Minister of Health and Sanitation. IHPAU will manage the project's fiduciary (financial management, procurement, and internal audit), M&E, and environmental and social safeguards; prepare the annual work plans and budgets; provide fiduciary and environmental and social reports; collate technical reports from the MoHS implementing partners; and send quarterly progress reports to the PSC and the World Bank. IHPAU will hold weekly meetings to review implementation progress, resolve problems, and make course adjustments as needed. The TL will organize a bi-weekly technical meeting to update the TTL of project implementation progress. He will ensure that the TTL is regularly updated on project implementation challenges.

District Level

District Health Management Teams (DHMTs)

42. **DHMTs, in conjunction with the Health Committees of the District Councils, in Kailahun, Bonthe, Falaba, Tonkolili and Western Rural will be responsible for oversight and implementation of the hub-and-spoke service delivery model in their respective districts.** PIH will support the DHMTs led by the District Medical Officers (DMOs) with technical assistance to implement project activities in their districts. The DMOs will coordinate and ensure timely implementation of project activities. They will report implementation progress to the national project coordinator, who in turn, will communicate implementation challenges to the World Bank through IHPAU team lead.

Partners in Health (PIH)

43. **PIH will fully implement the hub-and-spoke service delivery model in Kailahun District and provide technical assistance to DHMTs to concurrently implement the same model in the Bonthe, Falaba, Tonkolili and Western Rural districts.** PIH will be responsible for the management, coordination, and implementation of all project activities under component 1 in Kailahun District, while mentoring and coaching the DHMTs to carry out similar activities in the remaining four districts. A financial management (FM) assessment has been conducted and it found that PIH meets the World Bank's minimum requirements for the administration of project funds under the World Bank's Investment Project Financing



(IPF) policies and procedures. A procurement capacity assessment has also been completed. The assessment showed that PIH meets the World Bank’s minimum requirements but will be required to hire a procurement specialist with public procurement experience. In addition, the World Bank legal team has conducted due diligence of PIH and determined that PIH is eligible to implement World Bank projects in accordance with World Bank policy. The World Bank will sign a project agreement with PIH as an implementing entity with key performance indicators. PIH will also sign a cooperation agreement with the MoHS as the primary government counterpart. Through this agreement, PIH will fully implement the activities outlined in component 1 in Kailahun district and provide technical assistance to the DHMTs to implement in the other four districts. MoHS will ensure that deliverables are produced according to agreed timelines. Table 3 provides a summary of project components and key implementing entities.

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APPROVAL

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